An analysis of the factors influencing the implementation of health and personal social service policies for elderly people in Northern Ireland.

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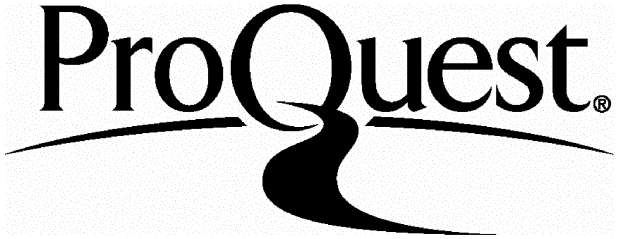

ABSTRACT

Community care has been an explicit policy goal in the United Kingdom since the end of the 1940s. The policy had traditionally taken the form of the provision of help and support in non-institutional settings, usually in the individual's own home. The services provided are intended to keep the individual in the community and out of institutions. Statistical data would suggest that there has been a huge expansion in domiciliary welfare provision. However, recent studies of such services suggest that the real gains made have not increased to the same degree as the per capita expansion in-services might suggest.

Alongside the observations about the outcomes of the explicit policy goal for community care there has been a growing awareness that policy implementation is not simply a continuation of the process of policy formulation ie implementation starts where policy stops. It has been argued that policy may be a response to pressures and problems experienced on the ground and it is essential, therefore, to look at implementation not solely in terms of putting policy into effect but also in terms of observing what actually happens or gets done and to seek to understand how and why.

The development of domiciliary services over the years has relied largely on professional judgments but despite this there has been relatively little research into decision-making related to the provision of the services and the closely related service of residential care. For this reason two case studies were conducted which examined, inter alia, the home help service and residential care decision-making processes.

Fieldwork for the study was carried out in the area of the Western Health and Social Services Board during 1982. Data collection involved interviews with the senior staff involved in the management and supervision of the social work assistants responsible for the provision of the home help service, the distribution of self-completion questionnaires to social work assistants in respect of recipients of the home help service and to officers-in-charge of old people's homes in respect of the residents in those homes. In addition information was also collected from the files of people newly admitted to old people's homes. The study raises questions about current Government policy, the rationing of services and the targeting of services to particular groups of the population.

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CHAPTER 1

INTRODUCTION

Throughout the United Kingdom approximately 94% of all elderly people live in private households in the community including about 5% in sheltered housing. Public policy aims have been to enable old people to live in their own homes for as long as their health and social circumstances permit. Statistical data would suggest that there has been a huge expansion in domiciliary welfare provision. However, recent studies of such services suggest that the real gains made have not increased to the same degree as the per capita expansion in services might suggest. This may be due, in part, to what one author describes as the rising tide of social isolation allied to the increased incapacity which has affected the very old living in the community (1). It may also reflect the provision of services to a larger number of people, irrespective of need, rather than an expansion of services designed, inter alia, to prevent admission to residential homes or hospitals (2).

Government policy has emphasised the complementary nature of hospital provision for the elderly and residential accommodation and, as early as the 1950s, official guidance was issued on admission to both types of units (3). Guidance on the criteria for admission to both psychogeriatric and geriatric hospitals has also been issued (4). The extent to which psychogeriatric patients are "misplaced" within the institutional care sector and the implications this may have for

their well-being were established as issues of major importance in the early 1960s (5). There is also evidence of "misplacement" on the one hand of old people of a high level of independence and on the other of those with excessive disability in residential homes - that is residents who do not need the degree of support offered by such homes and others whose requirements are beyond the scope of this type of care (6).

The period since the introduction of the National Health Service and local personal social services has seen major changes in the provision of a whole range of services for elderly people. Changes in treatment patterns and public attitudes have all contributed to the evolution of new approaches most significantly represented in the philosophy of community care. Successive governments have declared a commitment to developing a community based pattern of care in which a local network of facilities and services, both health and social services, support an integrated range of provision available through primary care and specialist teams, social work and voluntary contribution. Particular features of this policy include an emphasis on multi-professional teamwork; the need for considerable expansion of social services, especially domiciliary and day services; and a shift away from dependence on hospitals and residential homes as alternative services are gradually developed.

These aims have been widely adopted as an aspiration and subsequently reflected in government priorities and local (National Health Service

and Local Authority) strategic plans. So far, however, significant progress towards their implementation has been limited.

Processes of change are likely to reflect the influence of many different interest groups operating in a variety of ways. The results of inter-action between these influences will depend on the means available to give weight to different views, the channels through which these views can be expressed and the many aspects of agency structure which affect the distribution of power between groups. In the National Health Service the multi-tiered system of administration, with its complex relationships between officers and teams at different levels, has been widely perceived as causing diffusion of initiative and slowness of response (7). In the personal social services, the introduction of Seebohm, the incorporation of health department and hospital social workers in the new social services departments and the initial emphasis on "genericism", have continued to undermine existing forms of social services collaboration.

In addition to the problems of "influence" and "systems of administration" referred to above there has also been a period of severe restraint in public expenditure. Central government has for some time allocated high priority to the development of better services for the growing proportion of elderly people in the community but, in practice, realisation of this aim has itself been adversely affected by the complex organisation of the services and competition with other policy objectives. A major complicating factor is that establishing a new pattern of services for the elderly requires a substanial shift of resources into personal social services

provision in a situation where financing of local authority services does not permit central government to allocate funds with the specificity necessary if its policy is to be implemented. The advent of "joint financing" (8) has alleviated the problem in the short term but this still leaves local authorities ultimately having to pick up the revenue consequences of such joint projects and at least one commentator has suggested that events have scarcely justified the Department of Health and Social Security's initial optimism that the scheme would enable health authorities and social service departments to work together to a common end (9).

However, the inter-dependence of health, social and other local authority services in relation to problems of particular communities has been widely recognised. The need for collaboration in service delivery and joint planning at local level has been a continuing theme of central government guidance and a range of formal mechanisms has been established for this purpose (10). Nevertheless, the extensive differences in approach and organisation between Health and Local Authorities have made the realisation of this intention distinctly problematic.

In Northern Ireland the recognition of the need for collaboration in service delivery and joint planning led to a reorganisation of health and personal social services which is considerably different to that in England and Wales. The reorganisation in Northern Ireland in 1973 stemmed from 2 basic factors - a desire to follow proposals for the reorganisation of the National Health Service in Great Britain and a decision to reform local government in Northern Ireland. In 1969 the

Northern Ireland Government issued a Green Paper (11). This paper proposed the integration of the 3 parts of the health service under a system of nominated Boards, largely along the lines similar to the equivalent British proposals. The reasons given for this change were also similar to those in the English Green Paper, that the existing structure was tripartite while the individual's needs should be seen as continuous; that the separate branches of the health service were becoming increasingly independent, in treatment and care; and that a single authority for each area would more easily secure the most effective use of available resources. The paper proposed the integration of health and personal social services under an area board structure. The decision to integrate health and personal social services received remarkably little consideration in the Green Paper apart from a few references to "the need for co-operation and joint planning becoming recognised" and suggestions that "the best framework for the development of personal social services is to be found in their coming into some form of partnership with health services." The main reasons discussed in the Green Paper referred to administrative factors. Separate social work departments would have increased the number of administrative bodies and the number of administrative staff and supporting resources, and would have made co-ordination between social work and the health services more difficult.

The new structure was seen to have a number of important benefits for the people of Northern Ireland and for the staff working within it. The guidelines for re-organisation were: (12)

- The Ministry of Health and Social Services should be responsible for overall objectives, policies and resource allocation; the

Central Agency for providing selected services on an inter-area basis: the Area Boards for the planning and monitoring of services: and District Units for managing and delivery of services.

- The new organisation structure should balance the need for effective management in professional groups with the need to co-ordinate the professions contributing to programmes of care.

- A corporate approach to management should be adopted in order to establish a basis for the integrated planning, co-ordination and control of services.

- The organisation structure and the operating practices of the new organisation should be based on sound management principles.

- Overall objectives and a general policy for the provision of health and social services should be developed before the new structure is implemented.

The reorganisation was, therefore, an attempt to achieve a wide range of objectives. It would bring together into a rational framework, services which had grown in isolation and would provide channels of communication and co-operation between different groups of caring professionals. Integration and co-ordination would increase, it was argued, as understanding grew between the professions and as priorities were agreed on the basis of identified medical and social need rather than conflicting professional perspectives. The

identification of main patient/client groups such as the elderly and the physically and mentally handicapped was an attempt to put the needs of patients and clients before the interests of professions existing to meet those needs.

A fourth factor which has a significant influence on progress towards the implementation of government policies on community care is the role of professions in the health and personal social services. Professional influence on policy making and professional discretion in service delivery both make an important contribution to shaping provision. Professionalism can be a valuable source of commitment and a necessary support to individuals in the exercise of judgement. At the same time, however, the power of professional groups to shape their own activities and the difficulties of managerial scrutiny can pose awkward dilemmas: professional attitudes can also handicap innovation and prove a barrier to effective collaboration among those engaged in different aspects of care.

In addition to recognition of the power of the professional organisation, it is important to note, also, the growing influence of trade unions. Inflation, increasing militancy and a growing climate of conflict in industrial relations have all contributed to making trade union activity a significant determinant of policy and practice in service delivery.

The development of domiciliary services over the years has relied largely on professional judgement and has been influenced by demands from pressure groups. It is these influences, rather than the

statutory powers of the Secretary of State, which appear to have shaped the pattern of services at local level. In addition, the decision making process on the admission of elderly people to residential care has important implications for the use of resources and it is for these reasons, allied to some theoretical considerations which are discussed briefly below, that it was decided to study the implementation of policies for the health and personal social services for the elderly in Northern Ireland.

A general theme arising from a review of the literature on policy implementation during the past decade is that one cannot automatically treat implementation as the transmission of policy into a series of consequential actions. The relationship between policy and action needs to be viewed over a long time span and to involve a process of negotiation and inter-action between those who wish to put policy into effect and those upon whom action depends. The elements involved in the study of the process are - the environment from which needs and demands arise and upon which policy is supposed to have an impact; a political system in which policy and legislative decisions are made; and an organisational system through which policy is mediated and executed. Some of the most commonly held assumptions about policy implementation have their roots in the definition of policy offered by Pressman and Wildavsky (13).

"Implementation may be viewed as the process of inter-action between the setting of goals and actions geared to achieving them."

These assumptions are:-

a. there is a series of logical steps and implementation starts where policy stops;

b. there are two steps in formulating intentions: policy-making and creation of programmes which form the "input" to the implementation process;

c. implementation is a process of putting policy into effect.

However, more recent work by Majone and Wildavsky (14) has modified, and others (15) have challenged, this view of implementation as a policy centred approach by which a policy is the starting point for implementation and action. It has been argued that policy may be a response to pressures and problems experienced on the ground and that equally policy may be developed from specific innovation ie action precedes policy. It is considered essential, therefore, to look at implementation not solely in terms of putting policy into effect but also in terms of observing what actually happens or gets done and to seek to understand how and why. From this perspective implementation may be regarded as a series of responses. Responses to environmental pressures, to ideological commitment or professional orientation or to pressures from other agencies/actors seeking to influence or control action.

In common with other industrialised countries the United Kingdom has experienced a rapid expansion in the numbers of elderly people during the last 25 years.

Whilst there will be little change in the total number of elderly people up until the end of the century the proportion of people over the age of 75 will continue to increase before levelling off. Partly because of these demographic changes there is growing debate about the quality and purpose of community services provided for elderly people. Until recently the debate has tended to centre around the quantity of traditional services such as the home help service, meals on wheels, occupational therapy, day care and the community nursing services that could be provided to the elderly population. The obvious answer to the growing number of elderly people, especially the numbers of very old people has been to provide for an expansion of existing services - or more of the same.

In times of readily available finance such a strategy was possible. However the planning and provision of services must now be undertaken in a financial climate which is far from favourable to the expansion of services. Already the health and personal social services are facing growing demands from the elderly population and the real expansion in the number of those over 75 years of age, and who are most likely to need community support, has yet to take place in Northern Ireland.

Northern Ireland has to face a situation similar to that in the rest of the United Kingdom and the finance needed to meet the growing demand within the present structure of the services is not likely to be available. Financial budgets for health and social services are likely at best to remain at their present level or at worst to decline in real terms. Despite the comparatively generous provision of

community services in Northern Ireland the personal social services are already having to face up to uncomfortable decisions. They can either continue to provide the same service to a smaller percentage of the elderly population or they can spread a reduced service around a larger number of elderly clients.

Despite the high level of expenditure in Northern Ireland on the home help service there has been no systematic study of the recipients of the service and it was therefore necessary to undertake a study of the characteristics of the recipients in order to understand who was actually receiving the service and why. There has been a huge increase (159%) in the numbers of recipients of the service over a period of 10 years. Demographic changes and charging policies are insufficient explanations for this upsurge in provision and there is sufficient evidence from other studies to suggest that the procedures involved in the delivery of the service together with the decision-making activities of the staff involved in the adminstration of the service might provide some insight into the present pattern of provision.

The changes in the demographic structure of the elderly population have meant that in recent years heavy demands have been placed on both services and on families by the large number of people whose poor health and inability to care for themselves necessitate 24 hour supervision in some form. For many such people constant support and supervision is not available in their own homes, and in most cases the only alternatives available are hospitals or residential homes. The growth in the number of old people who require long-term institutional care has not been accompanied by a corresponding increase in the provision of hospital and residential facilities. Consequently,

both types of provision have come under increasing pressure to cater only for those most in need.

Residential homes for the elderly provided by local authorities were originally conceived as places where old people might choose to spend the last years of their lives in moderate comfort and security in the company of others. Many of the Poor Law Institutions which were designated as residential homes were not conducive to the creation of a satisfactory environment, but it was felt that the purpose-built homes which gradually replaced them would meet the need. In practice, residential homes have frequently been unable to serve the purpose for which they were originally intended and they have encountered many difficulties in providing an appropriate degree of care and supervision combined with a homely atmosphere. Despite the policy pronouncements to the contrary they have found themselves caring for the many chronically sick and disabled people who might have been expected to have gone into hospitals, although they have also continued to care for many others who are relatively fit and well.

The combination of demographic changes and the problems encountered in providing residential care for the elderly highlight the need to devote attention to questions of policy and practice in residential care. This has been further emphasised by the national economic difficulties during recent years and the escalating capital and revenue costs of building and running homes. On the one hand, attention has been focused on the provision of community services which are often seen as a lower cost alternative to residential care, and on the other hand, increasing emphasis has been placed on the need

to concentrate expensive residential services on those people most in need. It was for these reasons that it was considered necessary to conduct a survey of residents in homes to ascertain the degree of misplacement and to examine the policies and procedures influencing admissions and the decision making activities of staff engaged in placing elderly people in residential care. Because of the preventive nature of the home help service the case studies were seen as complementary.

Before embarking on the conduct of the case studies it was necessary to review the literature which relates to the implementation process to examine relevant theoretical issues. Thus in Chapter 2 a representative sample of the literature on policy analysis and related organisational theory has been reviewed to examine the existing theories and current knowledge on the implementation process. Following this, in Chapter 3, the present policies for health and social services for the elderly and their outcomes in Great Britain are reviewed. The main purpose of this chapter is to provide a "back-cloth" against which the local/smaller situation in Northern Ireland can be judged. Among the aspects covered are legislation; policy circulars and guidance on hospital services; residential care and domiciliary care; policy outcomes and current issues which includes some discussion on the concept of community care and on the issue of collaboration and co-operation between agencies. In Chapter 4 health and personal social serices for the elderly in Northern Ireland are reviewed and the evolution of these services examined. The areas to be covered are similar to those identified in the previous chapter but particular attention is paid to the period

between 1966 and 1981. In 1966 a review of services for the elderly was undertaken which resulted in the issue of a Memorandum on Services for the Elderly (16) and in 1981 a report of a reiew of services for the elderly was published (17). The development and conduct of the case studies is described in Chapter 5 whilst the results of the studies are presented in Chapters 6 and 7. In Chapter 8 the results of the studies are summarised and the implications of the findings are discussed and finally, in Chapter 9, the implications of the findings for the analysis of policy implementation are considered.

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CHAPTER 2

POLICY IMPLEMENTATION - SOME THEORETICAL CONSIDERATIONS

It has been suggested by Klein (1) that policy analysis as a phrase is relatively new but policy analysis as an activity has a much longer vintage and dates back to at least the first half of the 19th century. In a major article on the subject Heclo (2) suggested that there is a certain amount of definitional agreement on the term "policy" - it is usually considered to apply to something "bigger" than particular decisions, but "smaller" than general social movements. A second essential element on which there is agreement is that "policy is a course of action intended to accomplish some end". It is purposive. Despite the measure of agreement on these issues Heclo identifies ambiguity as to whether or not policy is more than the intended course of action. Some authors, he suggests, consider policy to consist only of the intended course while others include the actual behaviour implementing the intention. Heclo takes the view that the policy is not a self-defining phenomenon but that it is an analytic category, the contents of which are identified by the analyst rather than by the policy-maker or pieces of legislation or administration. He further states that "a policy may usefully be considered as a course of action or inaction rather than specific decisions or actions, and such a course has to be perceived and identified by the analyst in question". In noting that there was an emergence from a period of unusual barrenness in policy studies, he states that for most of the post-war period interest in the political system has centred on the inputs of

the political system, and to a far lesser extent on the "black box" of process and outputs of policy. Attention has only gradually extended from electoral behaviour to parties and interests groups and eventually come full circle to Government institutions and their actions in society. In concluding his article Heclo examines what he calls "analytic realism" in policy studies. He suggests that among political scientists attempts at systematic analysis are manifested most clearly in the proliferation of policy taxonomies. One can then expect a classification scheme from political scientists seeking both to be analytical and realistic. However although a great many schemes are in use he states that "academic efforts generally deal with the classifications of either policy processes or content and goes on to propose that "a perspective which views policy in terms of learning and adaptation offers the greatest promise for advances in policy studies which would be both analytic and realistic". This he concludes "is especially the case if one accepts the earlier view that policy should be defined so as to relate, not simply to direct decision, but to courses of action through time and outcomes which no one may intend or decide upon".

Given this clearly argued view of policy analysis it is difficult to understand why the study of the implementation process remained a neglected area of study for so long and has only relatively recently begun to be examined in some detail. Some clues as to why this state of affairs existed may be found in later articles on policy analysis.

Gordon and his colleagues (3) in a paper which attempted to clarify some of the issues involved in developing policy analysis as a

practical and academic activity suggest that ". . . researchers on the one hand adopt the assumption that policy-making is essentially a rational process based on the classic steps from a problem formulation and evaluation of alternatives through to implementation. Conflicts over goals or perceptions of the situation may be admitted but these are assumed to result in stable and determinate outcomes which do not interfere with the consistency of the system's operations. Typically, the problem is seen as technical, the climate as consensual and the process as controlled". They acknowledge that policy-making may be seen as a political activity into which the perceptions and interests of individual actors enter at all stages. Implementation then becomes a problematic activity rather than something that can be taken for granted as in the rational process model; policy is seen as a bargained outcome, the environment as conflictful and the process itself is characterised by diversity and constraint. They admit that the "power and survival" of the "rational system" is surprising given that its assumptions have been undermined by empirical studies of the policy process and that its predictive record is uneven. They suggest that the main reason for its continuing existence must lie in its status as a normative model and as a "dignified" myth which is often shared by the policy-makers themselves. Acceptance of the rational model helps the researcher towards a comfortable life; it enables him or her to appear to engage in direct debate with the policy-makers on the basis that information provided by the researchers will be an aid to better policy-making.

Ham (4) also advances some reasons for the neglect of the study of the implementation of policies. He examines approaches to the study of

social policy-making and identifies 4 traditions - descriptive; analytical; theoretical and normative. The normative tradition he suggests is dominant and is represented by a number of different strands of work. It is characterised by its committed concern for the recipients of social services; its focus on policy impact and its emphasis on empirical rather conceptual research. In reviewing the potential contribution of each tradition he states that both the analytical and the normative traditions have contributed to the understanding of the role of values in the policy process, in particular in exposing some of the assumptions behind different ideologies of welfare and social policy. Both the traditions have examined input into the policy process but their major focus has been on policy content and the impact of the social policies. They are particularly concerned with the effect of social policy on those at whom it is aimed. Consequently, he argues the process of policy-making and policy implementation have been ignored. Furthermore, he states that in some studies detailed examination of policy-making processes is seen as very much secondary to the more important task of analysing the wider context within such processes are located.

In an attempt to develop a conceptual framework for policy implementation Van Meter and Van Horn (5) acknowledge that conflicting uses of the concept of implementation are found in the existing literature and state that their definition is quite explicit: "Policy implementation encompasses those actions by public and private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions". They emphasise that

the implementation phase does not commence until goals and objectives have been established by prior policy decisions; it takes place only after legislation has been passed and funds committed. Therefore, they contend, the study of implementation examines those factors that contribute to the realisation or non-realisation of policy objectives. The authors suggest that their model and the research that flows from it are not designed to measure and explain the ultimate outcomes of Government policy, but rather to measure and explain what they prefer to call programme performance (the degree to which anticipated services are actually delivered). They recognise that some services could actually be delivered without having any substantial impact on the problem to which the policy is supposed to be related. Hence, successful programme performance may be a necessary - but not sufficient - condition for the attainment of positive ultimate outcomes.

They suggest that we know relatively little about the process of policy implementation. When faced with an unsuccessful programme, many observers attribute its failure to insufficient planning or the inadequacy of the programme itself. This attribution of blame is often unjustified. A study of implementation adds a new dimension to policy analysis. It gives the student, the politicians and the policy-maker a new understanding of how the system succeeds or fails in translating general policy objectives into concrete and meaningful public services.

Three main reasons are advanced for the lack of knowledge about the problems of policy implementation. These are:

1. The implementation process is assumed to be a series of mundane decisions and interactions unworthy of the attention of scholars seeking the heady stuff of politics.

2. The growth of Planning Programming Budget Systems may have encouraged policy analysts to ignore the problems of policy implementation.

3. The difficulty of the task has discouraged detailed study of the process of policy implementation.

In addition analysis of the implementation process raises serious boundary problems. It is often difficult to define the relevant actors. Many of the variables needed to complete an implementation study are difficult - if not impossible - to measure. Unlike legislative and judicial arenas where votes are often recorded, decisions in an administrative setting are frequently difficult to isolate. Finally, a comprehensive analysis of implementation requires that attention be given to multiple actions over an extended period of time, thus involving an enormous outlay of time and resources. To date, no one has advanced theoretical frameworks within which policy implementation can be examined.

More recently Barrett and Fudge (6) have suggested that most policy analysts have tended to equate policy <u>decisions</u> with action. They state that decisions are seen as the outputs of the policy process, the assumption being that once made they will be translated into action. Only lately have policy analysts started to focus on what

practitioners are only too well aware of, and what Dunsire has termed the "implementation gap". For this reason, they argue, policy does not implement iself, and attention is now being directed beyond policy-making towards the process by which a policy is translated into action and the factors influencing those processes. Later Barrett and Fudge contend that if one is faced with the pheonomenon of agencies upon whom action depends, but which are ideologically hostile and/or not susceptible to direct control "then implementation must be considered in terms of the nature of inter - and intra - organisational power relations, the interests of implementating agencies and the people in them".

The remainder of this chapter will be organised around these 3 major themes:

a. Inter - and intra - organisational relations;

b. Implementing agencies; and

c. The people in implementing agencies.

Inter - and intra - organisational relations.

The starting point for this sub-section is the book entitled "Implementation" by Pressman and Wildavsky (7) which Bowen (8) has suggested has occupied centre stage in the developing literature about policy implementation.

The book was unique at the time as it focussed on implementation - identified by the authors as "that part of the public programme that follows the initial setting of goals, securing of agreements, and the commitment of funds". The programme studied was an effort by the Federal Economic Development Administration in the United States of America to provide jobs for poor blacks in Oakland by offering public work grants and loans to local enterprise. In setting the scene for their work, Pressman and Wildavsky attempted to make a clear distinction between policy and implementation. "Implementation, to us, means just what Webster and Roget say it does: to carry out, accomplish, fulfill, reduce, complete. But what is it that is being implemented? A policy, naturally. There must be something out there prior to implementation; otherwise there will be nothing to move toward in the process of implementation. A verb like 'implement' must have an object like 'policy' but policies normally contain both goals and a means for achieving them. How, then do we distinguish between a policy and its implementation?

When a policy remains a disembodied objective, without specifying actors or the acts in which they must engage to achieve the desired result, there is no implementation to study. When the statement of the objective includes its attainment, implementation is unnecesary.

We can work neither with a definition of policy that excludes any implementation or one that includes all implementation. There must be a starting point. If no action is begun, implementation cannot take place. There must also be an end point. Implementation cannot succeed or fail without a goal against which to judge it."

They then go on to define implementation in the following terms:

> "Implementation does not refer to creating the initial conditions. Legislation has to be passed and funds committed before implementation takes place to secure a predicted outcome . . . to emphasise the actual existence of initial conditions, we must distinguish a programme from a policy. A programme consists of Governmental action initiated in order to secure objectives whose attainment is problematical. A programme exists when the initial conditions - the "if" stage of the policy hypothesis - have been met. The word "programme" signifies the conversion of a hypothesis into Governmental action. The initial premises of the hypothesis have been authorised. The degree to which the predicted consequences (the "then" stage) take place we will call implementation. Implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieving them".

The assumptions implicit in their definition may be deduced as:

a. there are a series of logical steps - implementation starts where policy stops;

b. there are 2 distinct steps in formulating intentions -

    i. policy-making (their initial conditions) and

ii. the creation of programmes which forms the inputs to their implementation process.

c. Implementation is seen as a process of putting policy into effect - the co-ordination and management of the various elements required to achieve the desired outcomes.

Pressman and Wildavsky then go on to examine the linkage of probability theory to implementation processes and demonstrate with considerable clarity that the longer the chain of causality, the more numerous the reciprocal relationships among the links and the more complex implementation becomes. One of the main arguments in this book is that one of the key reasons for "policy failure" is that policy-makers generally underestimate the complexity and difficulty of co-ordinating the tasks and agencies involved in implementing programmes.

About the same time an article by Ugalde (9) introduced the concept of "series of decisions". This he defines as "the total number of decisions which are made in the process of obtaining a goal". The series was divided into 2 phases.

- Programming decisions defined as those decisions which are made in the process of preparing a programme. These decisions could be made outside the public bureaucracy eg legislatures or in a bureaucracy other than the one which will be responsible for the implementation.

- Implementation decisions are those made in the process of implementing formal decisions. He suggests that several different bureaucracies make implementation decisions in the process of implementing one formal decision.

He then offers a tentative hypothesis that the relation between the time of programming decisions and the time of implementation decisions tends to be zero, the less effective and less numerous the organisations participating in the programming phase. On this basis he suggests that much of the effort in bettering public administration and planning should be directed to perfecting the decision-making system of the programme. He contends that if this is done the implementation phase will become easier and implementation of policies more certain.

Implementation problems have led one author, King (10), to suggest that Britain has become much harder to govern in the last 10 to 20 years. He suggests that there are a number of indications that this is so and cites problems in Local Government, the National Health Service, higher education, incomes policy and finally points to the difficulties that both major political parties seem to have in carrying out their election manifestos. It is argued that a large part of the explanation for this state of affairs can be stated in 2 propositions. The first is that the range of matters for which British Governments hold themselves responsible has greatly increased over the past 10 or 20 years as well as over the past 50, and is still increasing at a rapid rate. The second proposition is that, just as the range of responsibilities of Governments has increased, so, to a

large extent independently, the capacity to exercise their responsibility has declined. The author suggests that the difficulty lies not in the problem-solvers but in the nature of the problems. He offers 4 possible reasons for failure, all of them beyond the control of the individual would-be achiever -

1. what he set out to achieve was physically impossible;

2. he lacked the necessary resources, or had to contend with too many claims on them;

3. he was dependent upon someone else for the achieving of it, and the other person failed for some reason to do what was required;

4. he failed because he did not know or understand that which he needed to know or understand in order to succeed.

The third reason is considered by the author to be the heart of the matter. He contends that if Britain has become harder to govern it is almost certainly partly because the number of dependency relationships in which the Government is involved has increased substantially and because the incidence of acts of non-compliance by the other participants in these relationships has also increased substantially.

The themes on non-compliance and inter-agency dependency are also identified in the major work by Bardach (11) in the introduction to his book. The author identifies 3 principal perils of latter-day

public policy: after a policy mandate is agreed to, authorised and adopted there is (a) underachievement of stated objectives (b) delay and (c) excessive cost. He suggests that this is not a new phenomenon but rather that our consciousness of these problems has changed. In this respect he says there is scepticism about the intellectual foundations of liberal reform and that even when we know what ought to be done and can get political leaders to agree to mandate it, Government is probably ill-suited to the job. These he combines in what he has termed a third heresy. This heresy asserts that even if we know what to do, can get political leaders to agree to it and can devise an appropriate strategy of Governmental intervention, we may still not be able to ensure that the strategy will be well executed.

The most important approach to solving or at leat ameliorating this problem, he states, is to design policies and programmes that in their basic conception are able to withstand buffeting by constantly shifting sets of political and social pressures during the implementation phase. According to the author, however, design can only go part of the way. An important conclusion from the study is that the characer and degree of any implementation problems are inherently unpredictable. Even the most robust policy - one that is well designed to ensure the implementation process - will tend to go awry.

Bardach then undertakes a conceptual analysis of the implementation process. At first he outlines his own concept of the process as being in 2 main parts - "assembly" and "politics". In relation to

"assembly" he contends that it is important that the implementation process be understood, in part at least, as a process of assembling numerous and diverse programme elements. With regard to "politics" he states that the other part of his conception is grounded in the fact that these elements are in the hands of many different parties, most of whom are in important ways independent of each other. He goes on to suggest that the only way such parties can induce others to contribute programme elements is through the use of persuasion and bargaining. The resulting politics are in a form in which the very existence of a defined policy mandate, legally and legitimately authorised in some prior political process, affects the strategy and tactics of the struggle. The dominant effect is to make the politics of the implementation process highly defensive.

The author contends that his concept does not differ significantly from earlier scholarly work on the subject which he describes as "quite meagre". As the "implementation problem" has been perceived as an interesting social and political problem only in the last 7 or 8 years. He reviews the literature under 5 headings -

- implementation as pressure politics

- implementation as the massing of "assent"

- implementation as an administrative control process

- the implementation process as inter-governmental bargaining

- implementation and the complexity of joint action

In concluding his work Bardach refers to the work of Pressman and Wildavsky and states that in their attempt to examine what they call "the anatomy of delay" they have provided critical insight into the nature of the implementation process - it is shot through with gamesmanship. However, in Bardach's opinion the Pressman and Wildavsky approach does not go far enough. He argues that it suggests that typologies might be important, eg there are 3 or 4 types of delay processes but it stops short of suggesting a conceptual basis for such typologies. It is also limited to one specialist topic, delay. It does not explicitly identify and analyse implementation processes that result in the perversion or s ubversion of policy goals or the processes that lead to excessive financial cost. In addition it does not attempt to characterise in a moderately abstract and systematic way the interactions that positively link the different kinds of institutions or those normally involved in a process of programme assembly.

It is Bardach's need for a usable typology that has led him to the metaphor of "games". He states that as he lists, describes and analyses a series of implementation games he attempts to delineate the plausible inter-relationships among them. Of all the possible two-way relationships, only a minority seem to the author to be possibly connected with any degree of either strength or regularity. The political and institutional relationships in an implementation process on any but the smallest scale are simply too numerous and diverse to admit to our asserting law like propositions about them. He suggests

that it is the fragmentary and disjunctive nature of the real world that makes a general theory of the implementation process unobtainable and indeed unrealistic.

Bardach summarises the implementation process as:

1. a process of assembling the elements required to produce a particular programmatic outcome; and

2. the playout of a number of loosely inter-related games whereby these elements are withheld from or delivered to the programme assembly process on particular terms.

So far the literature reviewed has dealt largely with the relationships within and between organisations involved in the implementation process as "equal" partners. A major shift in this is provided by Hill (12). In looking at perspectives on the study of implementation, Hill says that the fashionable concern about implementation involves a shift from asking, "what is wrong with these policies?" to enquiring, "what is wrong with the implementation process and with the organisations responsible for implementation?" He goes on to suggest that the top - down model makes feasible a range of evaluative, impact studies which can look at, and perhaps even measure, delays, deviations and mistakes in the implementation process. He further states that without such an approach we are left merely to examine what gets done without any clear reference to what was intended. However, he takes the view that this is what many implementation studies must involve in practice - that is what the

"bottom-up" view of these processes looks like in reality in very many situations in which there is an unclear or unrealistic policy input from the "top", or in which the top-bottom distinction is a misleading one.

In dealing with the "centre/periphery" relationship he states that while he has rejected the notion that implementation can be interpreted solely in terms of the responses at the "periphery" to policy initiatives from the "centre" it is clearly important to give attention to the inter - and intra - organisational influences upon the implementation process. He takes the view that many problems of implementation arise from the centre's failure to comprehend the values, perceptions, motivations and definition of the situation held by peripheral actors. He then goes on to identify a number of different kinds of centre/periphery relationships which significantly influence the implementation process. The simplest model he identifies as that in which the centre and the periphery belong to the same organisation. The most complex he suggests occurs where policy implementation depends upon co-operation between the separate autonomous organisations, and particularly where responsibility at the periphery is (a) dedicated to several organisations with separate territories and (b) depends upon co-ordinated action between 2 or more local organisations.

He concludes that it might be appropriate to argue that in many policy areas central/local relations involve not so much a complicatedly inter-related policy implementation relationship but a two-tier policy-making process. He makes reference to the work of Judge who has presented central/local relations as involving a "trade off"

between "territorial justice" and "local autonomy" in which the central government concerned for the former is limited by political appreciation of the importance of the latter.

Implementing agencies alone do not occupy entirely the domain of inter - and intra organisational relationship problems. Pressure groups which may be internal to implementing agencies, but more likely to be external, can play a major part in influencing the implementation process. Richardson and Jordan (13) state that pressure group studies suggest that the public aspect of pressure group activity is merely the tip of the iceberg. The bulk of the activity lies below the "water line" and this is particularly true of pressure group influence on the implementation process. Once the decision is reached, once the policy is announced, once an Act is passed, there is a tendency for the issue concerned to leave the political agenda. In the eye of the public, "informed" by the media, the problem has been dealt with. There is little concern about what actually happens after that point. So groups are able to work quite effectively at the erosion of public policies away from the glare of publicity. It is suggested that the concept of policy erosion is well understood by groups themselves and can play an important part in the type and nature of amendments they propose during the passage of the legislation. Groups may well seek to amend the legislation as it passes through the legislature in such a way as to allow the maximum possible scope for erosion of the principles involved when the legislation comes to be implemented. With detailed procedures to be followed, the structures and institutions to be employed to deliver a particular policy, the type of personnel to be involved in the policy programme are all

extremely relevant to the so called "technical matters" that concern groups during the passage of legislation. Such matters are of increasing importance as the amount of delegated legislation increases. The more scope given by Parliament to Ministers to decide the details of policies, the more scope for groups to influence what actually happens at the point of policy delivery. The authors suggest that even where groups have not made a great issue of procedures and processes at the time legislation was passed, they may subsequently see opportunities in the implementation process to radically affect the way policies operate. The question of the degree of co-operation that groups will give in the administration of a proposed policy is of vital concern to the Government. Both sides realise the importance of the implementation process - after the set legislative battles, which change little, the real business of implementing, interpreting and modifying policy begins.

In addition to the negative and disruptive impact that groups may have on the implementation of policies, the authors suggest that there are numerous examples of cases where groups have played a positive and constructive role in the implementation of public policies. Indeed they state that most of the time groups do co-operate and assist the Government in the formulation and implementation of public policies and our system of public administration assumes that they will do so. One important aspect of their role in the implementation process is as part of the monitoring function of existing policies. In addition groups can and do play a role in the actual administration of policies as distinct from just the monitoring of the administration. The numerous voluntary associations in the field of social welfare have

been involved on a regular basis in the "delivery" of policies. The authors suggest that governments see advantages in using outside groups in the implementation of public policies, particularly in policy areas that are often thought to be politically sensitive. Occasionally, however, the closest relationship proves to be uneasy. The question of public funding of voluntary organisations has proved to be a rather thorny one, both from the Government's view point and from that of the groups themselves.

The authors argue that under certain conditions outside groups are more able than the Government to deliver policies effectively. There may be a number of reasons for this. The group may be regarded as more legitimate - more acceptable - by the potential recipients of the policy in question. They may have more local knowledge than the official bureaucracy and they may have more power. They may also develop a degree of technical expertise in a particular policy area that the public authorities do not possess. In such cases the group may play a more important role in the policy process than the public authorities themselves.

In concluding this section of the review relating to inter - and intra - organisational relations the work of Barrett and Fudge (14) is examined again and in particular their concept of "inter - action and the idea of negotiated order". They argue that agencies or organisations fulfil a variety of roles as policy-makers and implementors carrying out their routine or innovatory activities; as agents, in the sense of executing the policies and wishes of other organisations; as part of the environment affected by the policy

outcomes of others. Following from this the relationship between policy and action cannot be regarded as a simple transmission process but rather must be viewed as a complex assembly job involving the fitting together of different interests and priorities. It is further argued that the policy - action relationship is not a linear step by step progression by which a policy is translated into anticipated consequences, but is better described as inter-active and recursive. By this view the actions and re-actions of individuals and organisations may determine policy as much as policy itself determines action and response. Inter-actions between actors are considered as crucial arenas for understanding the policy - action process, and the authors have emphasised the importance of examining the particular organisational and administrative linkages used for implementation, and the negotiations and negotiative activity taking place. It is also suggested that policy cannot be regarded as a constant. It is mediated by actors who may be operating with different assumptive worlds from those formulating the policy and, inevitably, it undergoes interpretation and modification and in some cases subversion.

They state that conventional wisdom suggests that successful implementation rests on achieving consensus in the policy process. The reality is likely to be somewhat different, with conflict likely to occur at various stages throughout the policy process. This conflict may arise because of different interests and value systems, which may in turn reflect the impact of differences in the power structure in society, and differences in values concerning the policy direction and content. However, conflict must not be interpreted solely as a power struggle related to broad class interests, but also

as a question of relative autonomies within and between organisations or as issues of "performance" versus "conformance". It is suggested that even if it is possible to achieve a measure of consensus about policy objectives, or at least compromise around a particular form of policy, conflict may still occur in terms of the interpretation of what is meant to happen and the application of policy directives or rules. The authors contend that if we are dealing with process characterised by a multiplicity of linkages between actors and agencies in a variety of administrative divisions and inter-organisation dependencies, and with a variety of interests and ideologies, then first we need to understand the linkages, how and why they have arisen and how and why they are maintained or broken. They further argue that much of the theoretical work on organisations and administration is inadequate for explaining both the informal network of linkages and the broader social relations. What is needed they suggest is an analysis that accepts the importance of the microstructure and world of the actors' interactions and the interest and values involved, but can locate this understanding within the broader interest - power structure within society. They have pointed out the importance of recognising the cross-cutting nature of linkages between groups and agencies involved in implementing policy. They have suggested that the group of people involved in implementation does not necessarily reflect a formal organisational structure or hierarchy. They have also noted that in many cases actors and groups from several agencies are involved and do not have any "formal" relationships with each other. The way in which these individuals,

groups or agencies work together in implementing policy has been variously described as "creating" or "forging" new chains between policy and action.

Barrett and Fudge think that the idea of implementation structure is useful because it addresses the complexity and variety of linkages and interactions involved in "getting something done". It is free from assumptions about where action is initiated but rightly points to a process of creating networks of interaction that are essential to achieving action or performance. However they think that this approach still leaves questions about value systems and interests around policy issues, and the effect that lack of consensus and differences of interest have on the basic processes at work. This leads back to the question of the nature of policy and how far there are different sorts of implementation forces at work, one essentially "political and administrative", and one a continuing struggle over the direction of policy itself.

The idea of implementation as a negotiating process has come from an earlier discussion on the relevance of "control" and "compliance" as functions of policy-makers and implementors, respectively within the policy process. It has been suggested that control over policy execution or the ability to ensure compliance with policy objectives is the key factor in determining the success or failure of the policy. In opposition to this line of argument it has been suggested that compliance is not only a matter of control but also needs to be distinguished from the issue of consensus - the degree to which different actors and agencies are willing to share value systems, objectives and resources, and thus are willing to support and execute

particular policies and programmes. If the arguments about control and compliance are accepted and if implementation is defined as putting policy into effect, then compromise by the policy-makers would be seen as policy failure. However, if implementation is seen as "getting something done", then performance rather than conformance is the main objective and compromise a means of achieving it. The emphasis then shifts away from a master/subordinate relationship to one where policy-makers and implementors are more equal and the interaction between them becomes a focus for study. In examining interaction they found that negotiation, bargaining and compromise form central elements in the process. The major objection to the "negotiated order" approach relates to uncertainty of its ability to come to grips with matters of relevance to social structure. Those advocating negotiated order have tended to fail to come to grips with a concept of power and the power structure in society and thereby make assumptions about the freedom of action and the "action space" of actors in the policy or negotiating process. Too little attention has been given to the limits of negotiation.

Implementing agencies

There is a large amount of literature on the analysis of organisations and a great deal of research has been done on understanding the way they operate; describing administrative structures, examining the behaviour of groups and individuals in an organisational setting. It has been pointed out by Dunsire (15) that some of this literature recognises an implementation process and that many of the ideas currently being put forward as "new" by policy analysts and

practitioners have actually been around for a long time. Hill (16) also rejects the view that implementation is a new and hitherto neglected subject of study and illustrates this with reference to studies of British administration. However, Barrett and Fudge (17) suggest that this in itself is a problem. Much of the organisational literature treats the implementation of policy as a separate process more or less in a vacuum. Policy is made somewhere else and handed in, so to speak, to the administrative system which then executes it. The implementation process is seen as inextricably bound up with organisation structures and processes; that is, policy comes in at the top and is successfully refined and translated into operating instructions as it moves down the hierarchy to the "operatives" at the bottom.

Williams (18) suggests that there is great naivete about implementation and that it is important to learn that the implementation period for complex social programmes is not a brief interlude between a bright idea and opening the door for service. He states that the study of implementation carries us into social science's weakest area - dynamics - and goes on to say that the determination of whether or not a social programme or policy can be implemented must involve an analysis of whether technical, bureaucratic, staff and institutional/political elements can be blended into a viable process. He argues that bureaucratic and political factors represent the main near - term deterrence to more effective implementation. He offers an Implementation Paradigm ranging, on a "top-down" basis from Proposer/Initiator/Funder, through

Bureaucratic/Political layers; First-line Managers, Treatment Deliverers to Recipients. He then suggests that -

"generally speaking, the higher the Proposer/Initiator/Funder is in the hierarchical chain the denser and more complex will be the bureaucratic/political layers that must be worked through. But things are not much simpler at the local level. Whether the impetus for a proposed educational innovation comes from the national level or from the City School Superintendent's Office, the bureaucratic/political layers to be confronted will be relatively dense.

The most vexing problems in the implementation process are less likely to derive from big political or philosophical issues than they are from jurisdictional disputes. The person trying to initiate changes will often find specific direction blunted or subverted by lower-level bureaucrats trying to protect their turfs".

In exploring the nature of implementing agencies 2 contrasting approaches are reviewed. In the introduction to his article, Hasenfield (19) suggests that the burgeoning interest in the implementation of organisational change has emanated from the disturbing yet persistent documentation of failures by human service organisations to achieve the intended aims of new and innovative social service programmes. He suggests that one inescapable conclusion that has emerged from these studies is that the organisational context and processes in which these programmes are anchored play a critical role in determining implementation success or failure. He argues, however, that despite the number of such studies

there is yet to emerge a coherent theoretical perpective to inform research on this topic and to guide human service practitioners concerned with successful implementation of change in their organisations. He identifies 2 factors which may have contributed to this situation. Firstly, implementation studies in the human services have tended to be non-theoretical, lacking the clear organisational model to guide the research, and secondly the predominant focus in the study of planned organisational change has been on the socio-psychological processes determining the acceptance or rejection of change by organisational participants. He goes on to argue that within this perspective the issue of implementation is either ignored or trivialised to mean the need to achieve goal consensus, individual autonomy, and commitment to be changed by those who must carry it out. Several deficiencies in the human relations perspective account for this. First, it focusses on the behaviour of individuals in the organisations rather than the organisation as a whole, or the micro-level variables that define its character. Second, glaringly missing are the political and economic processes within and without the organisation that determine its core activities and shape its transformation over time. Third, changes are viewed as tinkering with and adjusting relations amongst staff, communication patterns, participation in decision-making and the use of authority rather than the development or modification of the organisation's care services.

The author proposes that implementation can be best understood from the political economy view of organisational change, concentrating upon shifts of power between units in the control of resource - allocation. He argues that unless changes occur in both power and

resources, organisations apparently display change but in practice do not effectively implement it. He further argues that effective change agents are able to mobilise external resources, possess technical expertise and occupy a central position within the organisation's division of labour. For example, a new drug rehabilitation programme might attract more support within the criminal justice system than within the mental health system, which it might threaten. Too often ideology passes as service technology (defined as, "a systematic body of knowledge of cause - effect relations specifying the techniques and procedures which lead to desired outcomes"). Within the organisation resistance to change which comes from the associated redistribution of inducements and rewards is best overcome by mobilising "organisitional slack" in the form of uncommitted money and manpower.

In conclusion Hasenfield suggests that in determining whether or not services to clients would actually be improved or not, what is crucial is not so much the initiation of change as the processes of implementing change. Agents of change must recognise the significance of both political and economic variables, operating both within and outwith the agency.

By way of contrast the second article, by Rosenthal and Levine (20) refers to the relationship beween case management and policy implementation. The authors set out to examine a class of service organisations which spend much of their resources processing and managing "cases". They suggest that for all such organisations the way in which cases are handled largely determines the match between

intended policy and actual organisation performance. The central assumption of the paper is that successful policy implementation requires a series of related actions: Goals must be translated into designs, designs into operations, operations into evaluations and controls, which in turn may lead to changes in goals, designs, and operations. In examining the importance of case management in Government all combine to make case processing a common administrative activity in the public sector. They further state that, as legislation that launches Government regulatory or service programme is typically vague, case processing becomes an act of elaboration aimed at consistent, responsible decisions. Such elaboration must occur in stages as the Government agency learns more about a case and begins to focus on a reasonable response to it. In comparing Government with a private sector they suggest that Government is characterised with the lack of tradition of planning, inadequte technical resources, political urgency to get a programme started shortly after the formal policy is defined, frequent lack of prior experience with the business or a new programme; and the strong likelihood that it would be difficult to predict in advance the range and volume of cases that will arise and the corresponding operational requiremens that are accordingly imposed on the programme. On this basis they argue one should expect that a series of small programmed decisions in Government will exert a large impact on performance and that policy in practice may differ considerably from policy in rhetoric.

The following management issues which have policy significance are identified.

- screening at the intake stage
- setting case processing priorities
- determining the scope of a case
- measuring the performance of processing activities
- staffing the case processing programme

In conclusion the authors argue that most implementation issues are considered to be "operational details" and receive little or no advance policy analysis or discussion; they are simply left to be worked out by programme managers and their staff. The central managerial challenge is to appreciate the variety and extent of operational discretion that must be left to agency personnel. Management must decide which staff positions should have what kind of discretion. They must develop staff trained to use this discretion wisely for the range of cases that are likely to arise. They must design their organisations and procedures to encourage professional use of such discretion. They must be prepared to modify existing policies when programme experience proves those policies to be unreasonable and finally and most importantly according to the authors these managerial actions must work together to create a case processing system that operates in a manner consistent with overall programme policy.

In concluding this part of the review it is worth noting Richardson and Jordan's (21) view that much of implementation depends upon the good-will and co-operation of participating groups for its success and because of this and because more groups have come to realise that we need to shift our focus, as political scientists, to what is termed

"the nastier problems which have to do with persuading, manipulating or coercing people to act in accordance with decisions that are made". They suggest that increasingly, the task for the decision-maker is to discover the limits set by those who would implement the decision.

People in implementing agencies

It has been suggested by Barrett and Fudge (22) that the way in which different "actors" perceive and make sense of the world helps to explain organisational behaviour and response. Individuals and the groups of actors, via the rules they establish (or absorb) for their own behaviour and the roles they occupy in organisations, not only influence the specific decisions of those organisations but also "embed" institutional structures with certain values and norms which will result in a distinctive organisational culture and tendency to promote certain interests rather than others. In attempting to understand the policy - action relationship it is necessary to go beyond the policy analysis which utilises organisational process and the bureaucratic politics models, and thereby undervalues by ommision the actor's perceptions of their organisational setting and purpose. It is important to look at actors' definitions of the situation and the subjective meaning they attach to their actions.

The main themes of this section are discretion and the activities of lower - level participants in bureaucracies. Reference was made earlier to the work of Van Meter and Van Horn (23) who developed a theoretical framework of the implementation process. Their work has been guided by 3 bodies of literature - (a) organisation theory; (b)

the impact of public policy, particularly judicial decisions; and (c) selected studies of inter-governmental relations. Primary attention is given to literature on organisational change and control since they believe that it has the greatest theoretical contribution to make and since it has been ignored generally by others studying the policy implementation process. Reference is made to numerous studies of change and control and it is noted that control has been discussed in terms of leadership authority, co-ordination, hierarchy, human relations, democracy, incentives and compliance. For the authors' purposes the final concept is considered the most useful. For them compliance may be seen as a special case in the study of implementation - usually related to the specific obedience or lack thereof to a law or directive. Yet studies of the process by which compliance is obtained or avoided gives us insight into the problem of implementation of complex policies in a fragmented political system. it is considered that the power of lower participants in organisations is enhanced by superiors who frequently have little idea of what their subordinates are doing. The monitoring of subordinate behaviour therefore becomes an important question in the study of complex organisations. The literature provides numerous insights into the conflicts between national, state, and local officials; it points to the inter-dependence of public officials at all levels of Government. it gives emphasis to the autonomy of subordinates in both intra - and inter - organisation affairs.

Hill (24) also deals with the characteristics of implementing agencies and suggests that attention needs to be given to the inter-action between complications to the implementation process which arise within

organisations and those that arise between organisations. He identifies 2 significant groups of literature which are relevant for this topic as the many studies by organisational sociologists which suggest the limitations upon the formal control of subordinates by means of rules and the behavioural studies of law enforcement which have emphasised the significance of bargaining and discretion in the activities of the police and other rule enforcers. Both of these strands he suggests are clearly relevant to an understanding of the limitations of the "top-down" model of policy implementation. They suggest first, that there are finite limits upon the prescription of subordinate behaviour and second that in most tasks and particularly in the more elaborate tasks there will be a strong element of discretion. He then identifies 4 sources of discretion:

i. a deliberate recognition of local autonomy;
ii. "political" difficulties in resolving key policy dilemmas;
iii. "logical" problems in prescribing "standards" and
iv. inherent limits to the regulation of tasks.

He states that inevitably in practice prescriptions for policy implementation convey discretionary powers to field-level staff for reasons which are combinations of these 4 sources of discretion. He then identifies what he terms "double discretion" in which, in a centre/periphery relationship, the centre grants extensive/ discretionary powers to a local agency and then the latter finds it necessary to allow a further high degree of discretion to its own field staff.

He suggests that the discussion of "control loss" arising from problems about rules enforcement and the existence of discretionary powers has involved a "top-down" perspective. He argues that the study of implementation must take into account not only developments in thinking about inter-organisational relationships but also this strand in organisational studies, which is best represented, in the literature on public organisations, in studies of hospitals and he identifies a similar vein in studies of field-level officials. He then introduces the concept of the field official as a "street level bureaucrat" whose job is characterised by inadequate resources for the task, by variable and often low public support for the role and by ambiguous and often unrealisable expectations of performance. He refers to the "two faces" of street level bureaucracy. It may be seen as effectively adapting policy to the needs of the public, or it may be seen as manipulating decisions of power in such a way as to distort policy towards stigmatisation, discrimination and petty tyranny.

The suggestion is then made that consideration of discretion and the roles of "street level bureaucrats" must also involve looking at the implications of professionalism for implementation. He identifies a variety of ways in which professionals influence implementation. The least of these he describes as "being able to interfere with the implementation process and get away with it" but more significant for the study of implementation than "subversion" of this kind is the large number of situations in which it is expected that professional judgement would have a considerable influence upon the implementation process. He acknowledges that there are some important questions here about the relationship between professional autonomy in dealing with

an individual relationship with the client and a policy-based concern about the way in which professionals allocate their services as a whole. In concluding this section he emphasises the key importance, at least for the "top-down" concern with implementation failure, of the motivaion of field level staff. This is an important issue even within the most integrated organisation.

Another article by Gummer (25) develops further the theme of discretion referred to by Hill. This article examines the power relationships between social workers and their clients as reflected in the amount of discretionary decision-making granted to social workers. The author suggests that in a power - dependent relationship one person is able to direct the behaviour of another because of the former's control of scarce resources needed by the latter. Many contacts between social workers and their clients can be classified as power - dependent relationships because of the role that social workers play as mediators between publicly and privately provided resources and the client. In this article the author attempts to provide a framework for a more objective analysis of the power balance between worker and client through the examination of discretion.

It is suggested that in order to explain scientifically the amount of discretion present in any situation, it is necessary to identify the major factors that cause it. These are put into 3 categories:

i. political and administrative aspects of society;
ii. theories and ideologies in the social work profession; and

iii. technical considerations in the caseworker - client interaction.

One can view politics as a system of activities to set and implement goals. The usual division of labour assigns goal-setting to legislative bodies and goal implementation to the executive branch. As with any activity, however, when one component of the system ceases to perform another component must assume that function if the system is to continue. This, the authors contend, is the situation in public policy, especially social welfare. Legislative bodies he suggests have become more and more reluctant to take unequivocal positions on policy pronouncements, with the result that goal-setting, if it is to be done, must be assumed by other parts of the system, most notably the administrative sector. It is this phenomenon he suggests that is referred to as the extension of policy formulation into administration. He states that a policy statement can be seen as a device for constraining discretion by imposing limits on the choices available to the decision-maker. It does this by specifying in detail the goal or goals about which decisions have to be made. When policy statements do not perform this function, that is, when they do not clearly and authoritatively define a purpose, they do not serve as constraints on those implementing the decision. The discretion available to the implementor is inversely/proportional to the specificity of the policy directive. He suggests that the policy formulation and administration are thus blended, and it is this mixture that provides the major structural source for administrative and worker discretion.

It is further suggested that social work ideologies refer to the body of systematically related beliefs held by professionals which guide practice. It includes beliefs about the aetiology of the problems confronting the client, and the prescriptions for appropriate action. The author suggests that the psychological orientation to social problems has important implications for the practioner's discretionary behaviour. This approach to social work practice maximises the amount of discretionary behaviour granted to the professional practitioner and minimises the prior specifications of what he or she can or cannot do.

The third set of factors which promotes discretionary behaviour has to do with the nature and organisation of the work done by social agencies. Here the author distinguishes between hard and soft services provided to the clients and suggest that clients of social agencies are frequently deprived of the capacity to withstand the agencies' arbitrary intrusiveness by the importance of the services. Social workers' discretionary behaviour is increased here, not so much because of the zeal of the worker but because of the client's specificity.

A second characteristic of the nature of the work is the organisational structure of typical social agencies. Units operate in a parallel rather than inter-related fashion, and supervision is based on the workers' report of what they are doing rather than as supervisors' direct observation of their work. Organisations with this structure have significant control and accountability problems since line workers are able to operate with a high degree of autonomy

and can screen their behaviour from the direct surveilliance of administrators. These structural conditions promote discretionary behaviour of workers who, in the privacy of the interviewing room, are free to interpret and apply agency policies and procedures as they see fit.

Normative aspects of discretion are examined and the author suggests that the normative question of how much discretion should be allowed to the worker can be approached by asking what role the client should play in the process. The opponents of discretionary behaviour insist that the rights of clients be spelt out, whether through rule-making by administrators or, if need be by litigation. The defenders of discretionary behaviour generally offer 2 arguments. The first has to do with the complexity of the clients' problems that prevents specification in advance of programmes for dealing with them. The second argument is based on social workers' claims to expert knowledge which entitles them to relative autonomy in making decisions.

Finally the author then goes on to look at the role of social workers in structuring the discretion. He suggests that since weak legislative mandates produce discretion, social workers in the policy arena can join with others advocating stronger, more consistent laws, particularly at the federal level. In order to play a role in this area, social workers will have to improve at drafting and reviewing legislation so that they can make themselves and their ideas useful to those legislators seeking to improve the quality of their proposals. A second way that social workers can play a significant role is to improve the administrative practices and procedures in organisations

that provide social services. The further area in which social workers can play a most important role is in the clarification of the profession's attitudes towards an approach to dependency.

Through their education and their position in society, governmental actors are already socialised into holding certain ideologies, beliefs and opinions before they join a governmental agency. On top of that, however, professional training and organisational socialisation provide further experience and define reality and set institutional and social norms, behaviour and modes of operation. Because of the scale, complexity and impact of public policy-making, the policy implications of professionalism become central to any analysis of policy-making and implementation. In many approaches to the study of policy this dimension is missing or barely mentioned. It is considered very important to understand the influence of administrative and professional ideologies and the way they infringe on the policy process.

Barrett and Fudge (26) suggest that in examining professional actors involved in public policy-making the "state mediation" model of a profession provides an accurate description. Those working at the local agency level have an additional element with which to contend, which in some cases gives them more of the characteristics of a "corporate patronage" model, with focus of their attention being given to locally determined needs and the duty to the employing organisation. This is particularly borne out in their resistance to political control, and public involvement and participation. This argument is supported by a considerable body of literature on the

impact of such ideologies on clients' experience of contact with state agencies. Professional and administrative ideologies are very influential in local and central government and the health service. What is often ignored, or at least downgraded is the much more specific influence of the profession in linking the public sector with the private sector, in influencing the context of national level debate, and in defining a detailed intra - departmental process of policy formation.

Interest in the theme of discretion prompted a series of workshops in England in 1978/79. The establishment of the workshops by Adler and Asquith was encouraged by a number of developments in social policy which had taken place in recent years. In the introduction to the book (27) in which papers from the workshops were published they state that the growth of bureaucracy and professionalism and of the powers of the state have lead to a situation in which the public are increasingly dependent on the decisions of administrators and professionals in the public services. Similarly, the growth of delegated legislation, administrative rule-making and Departmental codes of practice and the weak forms of professional accountability have meant that many of these decisions are not prescribed by statute but are instead left to the exercise of official discretion. Whether they are exercised by rule-making bodies or by individual administrators or professionals and whether they are concerned with the meeting of needs, the allocation of resources or the infliction of punishment, the discretion they exercise raises important questions of welfare, justice and accountability.

Adler and Asquith in their paper "Discretion and Power" (28) state that the growth of discretion has gone hand in hand with the growth of powerful professions with their claim to esoteric professional knowledge and they are able to support these claims through the development of powerful forms of occupational control. They further suggest that although fearful of "political interference" the power of the professions has been sufficient to protect them from public accountability and control. Thus although the Government is the main source of employment and remuneration for doctors, teachers and social workers, the doctor's clinical freedom, the teacher's control over what is taught in the schools and how it is taught and the social worker's decisions about what kind of help, if any, should be given are largely immune from any form of democratic accountability and control.

In the same collection of papers Young (29) addresses the issue of discretion as a source of "implementation problems". He states that traditionally such problems have been viewed as arising from control loss, a phenomenon which some will argue is a consequence of increasing societal complexity. He suggests that discretion is rooted both in the specific rules of formal autonomy and in the informal guidelines by which decision-makers operate. The interpretation of formal rules, the creation of informal guidelines and the exercise of preferences within them comprise a set of subjective factors which enable discretionary decision-makers to make sense of, and operate upon, their everyday world.

Young goes on to say that policy is rarely applied directly to the external world. Characteristically, it is mediated through other

institutions or actors. Thus the impact of policies is affected as much by the mediation of other key actors - the "implementers" - as by the intrinsic merits or feasibility of the policy itself. To recognise the crucial role of policy mediators is to redefine the policy process as the centre's manipulation of the external world via the manipulation of the actions of the periphery. The problem of central policy-makers becomes one of deploying instruments and influence to achieve desired ends. He recognises that the desired ends of central policy-makers often diverge from those of the mediators of policy in the peripheral agencies - usually attributed to crude clashes of organisational interest - "central control" versus "local autonomy". He suggests that a more subtle and a more valuable perspective, is to see "problems of implementation" as referring to the centre's failure to comprehend the values, perceptions, motivations and "definitions of the situation" held by peripheral actors. In other words practical policy analysis must be informed by an understanding of these subjective factors and their situational determinants.

Young concludes his paper by suggesting that the view of discretion as an implementation problem accords a central place to the analysis of the peripheral actor's situation and meaning-structures. The actions of implementers can only be understood in terms of their own "definitions of the situation". Given their subordinate position within the policy system, the definitions will often fail to match those of policy-makers; not only will they have divergent appreciations of problems but they will often attribute problematic

status to rather different phenomena. He summarises his argument as follows: the outcomes of the policy system are determined both by the degree of control over discretionary officials and by the extent to which they share the policy-makers' definitions of the situation, that is the degree to which they inhabit a common assumptive world. Where control is direct and the situation evokes a common appreciation on the part of both centre and periphery, then "policy implementation" may be said to occur. Where control is direct and there is no common appreciation, then "policy evasion" (the classic implementation problem) may be the response of the periphery. Where control is diffuse and there is no common appreciation, the pattern of outcomes will display "policy variation". Where control is diffuse but centre and periphery share a common definition of the situation, then "policy assimilation" has taken place. In neither of these latter cases is it helpful to speak of implementation or "implementation problems".

Discretionary decision-making in social work is examined by Smith (30). He acknowledges that the notion of discretionary decisions, rooted in the worker's own knowledge and skill is a crucial part of the collective self-image of social work as a profession. However he disputes the proposition that the ideally stated position that "professionals have largely unfettered discretion and make their decisions by reference to a body of esoteric knowledge" is an accurate account of situated decision-making behaviour. He suggests that in spite of the central position of discretion in the imagery of professional social work, a growing body of evidence indicates that social workers are probably behaving in ways which are very much more highly routinised than is generally acknowledged, certainly by social

workers themselves. He offers several grounds for believing this may be so. These are

i. the problematic relationship between professional and organisational practice is well established in research on health and welfare agencies;

ii. welfare organisations typically claim that they handle their affairs in a rational and responsible manner. It may be easier to make this claim if decisions are taken in a routine fashion;

iii. many social work texts discuss professional-client interaction as if it were invariably "face-to-face". Often it is not. Many of the most critical decisions in a client's organisational "career" may be taken when the client is not present, and with heavy reference to recorded material eg decision on allocation, case closure (if made) and any action taken on the basis of a case conference;

iv. it is a crucial feature of welfare agencies that there must be a regular and continuous flow of the "referral" through to a "client" through to effective "discharge". Most social workers certainly report that the demands placed upon themselves and their agencies are excessive and leave them little time to engage in what they regard as the most important aspects of their professional practice.

Smith contends that professional supervisors do not always understand (or acknowledge) the level of discretion that their so-called subordinates are exercising. It is this type of approach which led Lipsky (31) to guess that there are many contexts in which the latitude of those charged with carrying out a policy is so substantial that studies of implementation should be turned on their heads. In these cases, policy is effectively "made" by the people who implement it. Where considerable discretion characterises the jobs of people who implement public agency activities, people "make" policy in hidden consort with others in similar positions through their patterned responses to the situations and circumstances in which they find themselves. He contended that an alternative approach to the study of policy implementation is available if we focus analysis on those who are charged with carrying out policy rather than those who formulate and convey it. Lipsky developed this alternative approach and formulated, what was described by Hill (32) as "an important new body of theory on the roles of street level bureaucrats". In his work Lipsky (33) portrays the field official as a "street level bureaucrat". His job is characterised by inadequate resources for the task, by variable and often low public support for the role, and by ambiguous and often unrealisable expectations of performance. His concerns are with the actual impact of specific policies upon his relationship with specific individuals; these may lead him to disregard or fail to understand the wider policy issues which concern those "higher" in his agency. The street-level bureaucrat as a scapegoat for policy failure is a familiar figure. Moreover his role is uncertain. A modicum of semi-professional training defines the role as the actualisation of a set of ideals inculcated in that training. Yet the street level

bureaucrat is also the representative of a governmental agency, one which is itself subject to conflicting pressures. The street level bureaucrat, in day to day contact with the clients and with the community at large, becomes to some degree locked into the support of individuals and groups who may be antipathetic to his employing agency. In this situation of role strain, the person at the end of the line is not disposed to react to new policy initiatives from above as if he were a mere functionary; they are but factors in a whole web of demands which as a peripheral actor he has to manage.

Given the importance of discretion and the emphasis on the activities of street level bureaucrats it would be appropriate to conclude this review with a brief reference to the theory of rationing and its practice in relation to the providers of personal social services.

Judge (34) states that as far as rationing in the personal social services is concerned there is no satisfactory theoretical framework within which to develop a discussion. However, he makes a distinction between financial rationing and service rationing. The former he defines as being concerned with those procedures by which sums of money are allocated between competing claims and the latter he refers to as those procedures, implicit or explicit, by which clients obtain access to social policy goods and services. He then distinguishes 4 groups who are responsible for the allocation of resources. Politicians, or elected representatives, of the ruling party or coalition are involved in a great deal of decision-making about resources. This group is usually more involved in financial than service rationing. Bureaucrats, or managers, are continually involved

in making financial allocations and in supervising and guiding a good deal of service rationing. Professionals are more usually concerned solely with service rationing at the client interface. The last group he categorises in 2 ways. First there is the consumer/voter who has a positive but indirect effect on rationing by his sometimes inconsistent mixture of demands for tax and welfare policies. Second, there is the consumer/client who has a more direct but negative impact on rationing. In looking at how resources are rationed Judge notes that the demands for social services, especially when provided at or near zero price, is potentially infinite, but resources, by definition are scarce. How does one establish an equilibrium between demand and supply? A suggestion from Parker (35) is that there are broadly 3 groups of rationing strategies. The first strategy is restrictive and involves the use of either explicit or implicit deterrence; the use of eligibility criteria, charges or delay. The second strategy is labelled dilutant and requires reductions in the level of service provided to individual clients. The final strategy is to terminate the service being provided sooner than is desirable.

For the purposes of this work the idea of service rationing is the most important and Judge states that it is probably one of the most important functions of social services departments but that our understanding of what actually happens is very limited. There has been almost a conspiracy of silence about what social workers actually do with one of their most valuable and expensive resources - their own time. He suggests that what limited work has been done in this area has produced preliminary hypotheses of considerable policy relevance which are well worth pursuing. For example, it is suggested that

social workers often give actual priority (in terms of hours allocated) to those clients with simple needs that can be satisfied in the short-term. In other words it is possible that many social workers are allocating a disproportionate amount of time to relatively low priority cases because of the social worker's need to derive what may be an inappropriate amount of job satisfaction by producing tangible outputs at regular intervals. At the other extreme it is quite possible that another type of social worker allocates too much in cases where, although they are important, very little can be achieved.

Foster (36) distinguishes between formal and informal service rationing. The formal types of rationing identified are eligibility rules, official waiting lists, charges and means tests. The main advantage claimed for these formal overt types of welfare rationing is that they are open to public scrutiny and criticism. On the other hand the informal methods of welfare rationing are usually less obvious and less open to scrutiny than formal methods. She suggests that most individual welfare providers, but particularly professionals, are free to implement their own personal and informal rationing systems. Delay, dilution, deterrence and withholding of information are all methods of informal welfare rationing. Social workers sometimes take weeks to respond fully to a request for help, whilst general practitioners may delay patients access to them by a variety of strategies. General practitioners and social workers may also decide to spend less time with their patients/clients than they judge to be necessary. They will rarely inform consumers that they are receiving a diluted service. Dilution is therefore a particularly

difficult method of rationing to detect and scrutinise since clients themselves may be unaware that it is taking place. In relation to deterrence Foster suggests that welfare providers can use a variety of strategies to deter excess demand or unpopular clients eg they can be deliberately rude to clients in an attempt to deter them from further using their services. The final form of informal rationing is with-holding information. If claimants or clients are unaware that certain benefits or services exist they will not demand them.

Whatever form informal rationing takes Foster has identified 3 kinds of disadvantage which results. First, it fails to secure uniform treatment for clients with like needs. If individual welfare providers, professional or not, are free to take personal decisions about whether particular clients should receive help, welfare consumers with similar needs will inevitably receive different amounts and types of help. Second, it is very difficult for a dissatisfied client to challenge or appeal against an informal or covert decision. Third, social policy-makers cannot ensure that their intentions are being carried out if their policies are at the mercy of uncontrolled individual decision-making. This last point is important to the consideration of policy implementation.

Conclusion

A representative sample of literature on policy implementation which has appeared over the last decade has been reviewed. This concluding section will attempt to highlight some of the more important issues which have emerged over that period.

By way of preface it is perhaps worth noting the pessimistic tone of some of the major studies. Pressman and Wildavsky's study (37) with which the review started suggests almost insurmountable difficulties in obtaining the necessary clearances to achieve implementation. Bardach (38) suggests that the Government ought not to do many of the things liberal reform has asked of it and even if Government does pursue appropriate goals it is not well suited to achieving them. On the British scene Barrett and Fudge (39) also end on a pessimistic note by suggesting that "policy may become a substitute for action, to demonstrate that something is being done without actually tackling the real problem". These views are representative of the debate about Government effectiveness in which concern centres on the appropriateness of public intervention and the relevance of public policy in relation to problems and issues.

A general theme to arise from this review is that one cannot treat implementation as the transmission of policy into a series of consequential actions. The relationship between policy and action needs to be viewed over a long time span and to involve a process of negotiation and interaction between those who wish to put policy into effect and those upon whom action depends. The elements involved in the study of the process are

- the environment from which needs and demands arise and upon which policy is supposed to have an impact;

- a political system in which policy and legislative decisions are made; and

- an organisational system through which policy is mediated and executed.

Some of the most commonly held assumptions about policy implementation have their roots in the definition of implementation offered by Pressman and Wildavsky, "Implementation may be viewed as a process of interaction between the setting of goals and action geared to achieving them". These assumptions are

a. there is a series of logical steps and implementation starts where policy stops;

b. there are 2 steps in formulating intentions: policy-making and the creation of programmes which form the "input" to their implementation process; and

c. implementation is a process of putting policy into effect.

However more recent work has challenged this view of implementation as a policy - centred approach by which policy is a starting point and implementation a logical step by step programme from policy intention to action or which assumes that policy comes from the top and is the starting point for implementation and action. It has been argued that policy may be a response to pressures and problems experienced on the ground and that equally policy may be developed from specific innovations ie action precedes policy. It is considered essential, therefore, to look at implementation not solely in terms of putting policy into effect, but also in terms of observing what actually

happens or gets done and to seek to understand how and why. From this perspective implementation may be regarded as a series of responses - to environmental pressures; to ideological commitment or professional orientation, or to pressures from other agencies/actors seeking to influence or control action.

It is with this background that the examination of Health and Social Services for elderly people will be approached.

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CHAPTER 3

LEGISLATION, POLICY AND POLICY OUTCOMES IN ENGLAND AND WALES

LEGISLATION

Services for the elderly have been strongly influenced by the provisions of the Poor Law Amendment Act of 1834 which sought to reduce the cost of public relief by introducing a workhouse system. Workhouses continued to be the main stay of public provision for the elderly throughout the 19th century and into the 20th century. Following the First World War, it was assumed that the payment of pensions would reduce the need for workhouses but whilst pensions did alleviate poverty to some extent they made little impact on the needs of the infirm. Indeed, the advance of medicine and public health in the early 20th century changed the age structure to such an extent that by 1946 there was a greater number of elderly in workhouses than there had been in 1900.

Present day health and personal social services for the elderly have their bases in 2 important enactments, the National Health Services Act 1946 and the National Assistance Act 1948. Section 1 of the National Health Services Act placed a duty on the Minister of Health to promote the establishment of a comprehensive health service "designed to secure improvement in the physical and mental health of

the people of England and Wales and the prevention, diagnosis and treatment of illness". More specifically Section 3 (1) stated that "... it shall be the duty of the Minister to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements, accommodation and services of the following descriptions, that is to say:

a. hospital accommodation;

b. medical, nursing and other services required at or for the purposes of hospitals;

c. the services of a specialist, whether at a hospital, a health centre provided under part III of this Act or a clinic or, if necessary, on medical grounds, at the home of the patient."

In addition to these "hospital and specialist" services section 29 of this Act enabled local health authorities to make arrangements for providing domestic help "when such help is required owing to the presence of any person who is ill, lying-in and expectant mothers, mentally defective, aged or a child..."

The National Assistance Act 1948 was, among other things, an Act to terminate the existing poor law and to provide for the assistance of persons in need by the National Assistance Board and by local authorities; to make further provision for the welfare of disabled, sick and other persons and for regulating homes for disabled and aged persons. While the Act did develop the ability of local authorities

to provide care to people in their own homes the main emphasis remained on residential care and section 21 (1) of the Act placed a duty on local authorities to provide - "residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them."

It was not until the 1960s that any legislative changes significantly reinforced the preference for community services which now prevails although some experimental provision was made by voluntary organisations during the 1950s. The National Assistance Act 1948 (Amendment) Act 1962 provided an important incentive to the development of community care as it gave local authorities the power to provide meals and recreation for old people in their own homes or elsewhere. These services could be provided directly by the local authority or through a voluntary organisation. The Health Service and Public Health Act 1968 extended the range of clients eligible for the home help service and the Chronically Sick and Disabled Persons Act 1970 encouraged a wider range of service provision to the disabled, including the elderly disabled, than had previously been made.

POLICY AND POLICY OUTCOMES

Hospital Services

The primary aim of policy in the care of the elderly is designed to help them to maintain independent and full lives in their own homes for as long as possible. Hospital provision seeks to facilitate this

aim by stressing the rehabilitative and preventative functions and practices so as to facilitate early discharge and reduce the need for long-term care. Current departmental policy is as follows. Circular HM(57) 86 (1) stressed that the first aim should be to make adequate provision whenever possible for the treatment and care of old people in their homes. It also urged hospital authorities to develop out-patient services and day hospitals and to set up in every hospital centre a geriatric department under a specialist physician. It considered that in areas where there was a fully-effective geriatric service, adequate domiciliary and welfare services and normal age distribution, a bed provision of 1.2 per thousand population would give a reasonable hospital service. This figure was later redefined as 10 beds per thousand population aged 65 or over to allow for variations in population patterns.

A comprehensive definition of a hospital geriatric service is contained in HM(65) 77 (2). This indicated that the essential elements of a geriatric department were:

1. An adequate number of beds for assessment, treatment and rehabilitation closely associated with the general wards of the principal hospital and of longer-stay beds which could be either in the principal hospital or at a long-stay or peripheral hospital;

2. Appropriate outpatient and day hospital facilities;

3. Co-ordination of the demands of geriatric and other departments for all kinds of staff and for diagnostic and treatment facilities to ensure that the geriatric service had an adequate share;

4. Appointment of a consultant to take charge of all beds specifically for the elderly (except those in psychiatry) and to advise other departments on the care of the elderly;

5. Close co-ordination of geriatric and psychiatric services. An effective geriatric service would provide for prompt admission to hospital where necessary; full assessment of need, preferably at an outpatient clinic or at home, so that the appropriate treatment could be given immediately; consultation before discharge to ensure that adequate arrangements for care are made; the location and planning of long-stay accommodation to enable links with family and home area to be maintained and provide for short-stay admission for the relief of relatives.

The categories of patients in a geriatric department would include the acutely ill and those admitted for investigation, assessment and short-term curative convalescent and rehabilitative treatment, together with those who remain incapacitated and barely mobile or have long-term or terminal illness and who require continuous medical or nursing care of a kind which could not adequately be provided for in their own homes.

Circular HM (70) 11 (3) recommended that joint assessment units be set up, normally in the geriatric department of a district general

hospital, to allow geriatric and psychiatric assessment and appropriate placement for those patients who appeared to be suffering from both physical and mental illness. A unit of 10 to 20 beds was thought adequate for a total population of 250,000.

Circular DS329/71 (4) gave advice on the siting of geriatric services and concluded that about half of all geriatric beds (ie 5 beds per thousand aged 65 and over) would be required for assessment, immediate treatment and intensive or planned rehabilitation and should therefore be located in a district general hospital. The remaining beds (a further 5 per thousand elderly), which would be needed for less intensive rehabilitation and for longer-stay patients, might be included in a hospital separate from the district general hospital, providing also for other inpatient services and day hospital facilities and servicing a sizeable local community. Guidance was also given on geriatric day hospitals. Their main function was seen as rehabilitation and assessment; some inpatients, especially those nearing discharge might also use the facilities. Attention was drawn to the essential differences from day centres, which fulfil a social as distinct from a medical need. A provision of 2-day hospital places per thousand elderly population was considered adequate with a recommended size range of 20-50 places.

Circular DS95/72 (5) set the minimum standards for staff and facilities in geriatric departments. The standards were set at the minimum tolerable level and took into account the resources and manpower likely to be available in the succeeding 2 or 3 years; it was hoped to be able to raise the standards later. The main minimum

staffing standards were:

- Medical Staff: 1 geriatrician and adequate supporting staff in each district;

- Nursing staff: one nurse to 1.9 inpatients in wards of 30 or more beds, with up to 2 more staff in the smaller units;

- Domestic staff: 2.7 domestic staff hours per in-patient week.

The Consultative Document on Priorities for the Health and Personal Social Services in England (6) stressed the importance of providing acute geriatric beds in district general hospitals and the contribution they would make to the better use of available resources. Interim targets were proposed to secure more rapid progress towards a satisfactory pattern of geriatric provision. It was suggested that in all health districts a minimum of 10% of geriatric bed need, or one geriatric ward, should be provided in general hospitals by the end of 1976/77 and at least 30% of bed need by the end of 1979/80. This was an interim minimum target and authorities were asked to proceed to the full 50 target set out in Circular DS329/71 as fast as possible. Broad objectives in the Consultative Document were confirmed in "The Way Forward" (7).

The care of elderly people with mental disorder forms part of the responsibility of psychiatric services. Government policy on the future pattern of these services is set out in the White Paper, "Better Services for the Mentally Ill" (8).

It is based on the development of a network of health and social services in each district including a general hospital psychiatric unit, day hospitals, longer term accommodation for the elderly severely mentally infirm, community psychiatric nursing services, local authority residential and day care and social work support. Central government guidance on the provision of services for this group is contained in Circular HM (71) 72 (9).

In May 1980 the Department of Health and Social Security issued a Consultation Paper on Hospital Services (10). This paper noted that hospital policy for the 1960s and 1970s was to concentrate hospital services in major hospitals with only a limited range of services remaining in small local ("community") hospitals. It further stated that "it is proposed that this policy be changed to place less emphasis on the centralisation of services in very large hospitals and to allow for the retention of a wider range of local facilities." It is recognised that the changes proposed in the paper would have repercussions for certain patient groups and suggested that substantial changes would be necessary.

Bed Usage

Although the use made of hospital services by individual elderly patients of any age will always vary, the general picture shows that the need for hospital services rises sharply from 75 years onwards.

In 1974, the average number of non-psychiatric hospital beds occupied daily by patients aged 65 to 74 years was 7871 beds for every one

million population in this age group: the comparable figure for people aged 75 and over was 24,289 beds. In other words the "very elderly" used proportionately over 3 times as many hospital beds daily as the "less elderly". Tables 1 and 2 show the use made of hospital services in 1979 by patients aged 65-74 years and 75 years and over for all non-psychiatric beds and for major specialties used by the elderly (on the tables HIPE stands for Hospital In-patient Enquiry). Table 1 shows that of patients aged 65 to 74 years with medical conditions, the great majority are treated in departments of general medicine, while many more of those aged 75 and over are treated in departments of geriatric medicine.

Most hospital specialties will be affected to some extent by the increase in the 75 plus age group; while the major burden will fall on the departments of geriatric medicine, any significant increase in the proportion of patients in this age group in general medical, general surgical and orthopaedic beds is likely to have a major impact on the overall length of stay in these beds, and by so doing could considerably reduce the resources available to other sectors of the population. This is a particular risk where there is not an effective geriatric service or in wards where staff are not adequately trained and experienced in the particular problems of the "very elderly" and fully alive to both the need and potential for early and active clinical and social rehabilitation.

Many of the health problems from which elderly patients suffer are similar to and no more complicated than those of younger patients.

TABLE I AVERAGE NUMBER OF BEDS USED DAILY BY ELDERLY PATIENTS

HIPE 1979 (ENGLAND AND WALES)

Specialty	Total Occupied Beds	65-74		75-84		85+	
		No of beds	% of beds	No of beds	% of beds	No of beds	% of beds
All non psychiatric	164808	33993	21	41961	25	21623	13
General medicine	25230	6996	28	4889	19	1515	6
Geriatric medicine	53004	10796	20	24152	46	15579	29
General surgery	22625	5559	25	3684	16	789	3
Orthopaedic surgery	17196	2945	17	3492	20	1714	10
GP med (ex maternity)	5842	1505	26	2100	36	1274	22

TABLE 2 MEDIUM DURATION OF STAY (IN DAYS) OF PATIENTS

HIPE 1979 (ENGLAND AND WALES)

Specialty	All Ages	65-74	75-84	85+
General medicine	7	9	10	11
Geriatric medicine	20	17	19	21
General surgery	5	8	9	8
Orthopaedic surgery	5	13	16	18
GP med (ex maternity)	10	12	14	14

However there is a range of conditions and symptoms characterising many elderly patients which become increasingly evident after the age of 75. These may be summarised as follows:

i. The multiplicity of clinical problems existing in one patient;

ii. The risk of sudden onset of confusion and its continuance when illness occurs, especially following admission to hospital;

iii. The complicating factors of normal ageing;

iv. The slower pace of recovery;

v. The danger of permanent immobility developing from confinement to bed;

vi. The chronic nature of illnesses;

vii. The frequent presence of residual disability;

viii. The greater importance of adverse social and environmental factors eg a lack of home support, low income, poor housing;

ix The existence of emotional and psychological problems in relation to the patient's prognosis.

Unless treatment and care are given by a team of staff trained and experienced in dealing with these problems, development of chronic conditions and creation of the need for long-term care may follow.

The average number of available geriatric beds in England in 1980 was 54,900 equivalent to 7.8 beds per thousand population aged 65 and over but varying from 7 to 11 beds in different regions. Higher figures in some cases reflect deficiencies in adequate facilities for acute geriatric medicine and early active rehabilitation leading to a more custodial service. They may also be due to deficiencies in provision for elderly severely mentally infirm patients. Although it has been Departmental policy for some years that a substantial proportion of geriatric beds should be in district general hospitals with easy access to diagnostic and therapy facilities, many health districts still have no geriatric beds in general hospitals and main district general hospital sites where diagnostic and acute medical facilities are located. An analysis of NHS Regional Strategic Plans for 5 regions showed that in 1975, a total of 21 districts (30%) had no geriatric beds on the main district general hospital site, and over half of these would still have none by 1986, unless reallocation of beds could be agreed or additional capital resources were allocated to their provision. Moreover many geriatric beds are still in old and unsatisfactory accommodation unsuited to the needs of a modern geriatric service with its emphasis on active treatment and rehabilitation. An analysis of reports on 6 regions in 1971 to 1975 show that in some regions 50% or more of the beds were in 19th century or older buildings, up to 60% were in of old workhouses and many others were in ex-isolation hospitals or sanitoria, or converted houses.

The factors determining whether medical cases are admitted to a geriatric bed or general medical bed depend very much on local practice as well as available facilities. The type of service currently provided by different Departments of geriatric medicine also varies considerably, and ranges from an age-related admissions policy with total care of the patient, including emergency medical admissions for all patients over a certain age (varying from 60 to 80 years in different districts) to one of mainly long-stay care as a back-up for other specialties.

An analysis of Health Advisory Service Reports and 1974 SH 3 statistical returns for the geriatric departments in 15 districts considered to provide a good service and 15 considered to provide a generally poor service show the wide range of variations in facilities, performance and staffing. Average district lengths of stay range from 25 to 280 days. The ratio of geriatric beds to one thousand population aged 65 and over in these districts varied from 3.0 to 18.2, compared with the Department's norm of 10 beds per thousand. Only 1/3 of the "good" services, as against over one half of the "poor" services, had bed provision at or above the norm but 11 of the "good" services compared with only 2 of the "poor" services had 30% or more of their geriatric beds in district general hospitals. Most of the "good" services had an above average ratio of consultants in geriatric medicine with good junior medical support; there was no consultant in geriatric medicine in 1/3 of the "poor" services. The quality of hospital geriatric services may also be related to a number of other factors, such as the level of provision of local authority services. It is clear that in the foreseeable future the pattern of

hospital provision for the elderly will of necessity continue to vary according to the manpower and facilities available, in particular the existence of acute geriatric medicine facilities in district general hospitals, the nature and extent of consultant cover, the arrangements for medical cover in community hospitals and the manner in which local facilities available for diagnosis, treatment, rehabilitation and continuing care can be best deployed. There are, however, certain main lines of approach both in the acute and continuing care fields.

The main options emerging for the treatment of elderly patients with acute medical conditions are either the continued development of Departments of geriatric medicine, operating age-related admissions policies, under fully-committed consultants in geriatric medicine, or the appointment of consultant physicians with a special responsibility for the aged with training in geriatric medicine and experience of the geriatric hospital service in the needs of the elderly, who would have sessions both in geriatric and in general medicine or some other medical sub-specialty.

Districts which are already operating an acute geriatric service have reported that their need for longer-stay geriatric beds has been reduced (provided there are sufficient residential places and beds for elderly severely mentally infirm patients in the district) and that a smaller proportion of patients than had previously been expected are found to need continuing hospital care. The amount of provision required for such patients needs further consideration to assess the impact of the increasingly acute pattern of geriatric services on the

one hand and the growing numbers of very elderly patients on the other hand. It is, however, clear that there will always be some patients who do not respond sufficiently to be discharged to home and for whom continuing care facilities must be provided. Current policy for provision of facilities for slow rehabilitation and continuing care proposes that beds for geriatric medicine should be sited in small local community hospitals, near patients' homes, where there will also be acute and general practioner beds. While the consultant would normally retain some clinical responsibility for the geriatric beds, particularly for admissions and discharges, day-to-day medical cover would normally be provided by general practitioners. It is, however, becoming apparent that while no problems are anticipated in the development of community hospitals in some districts, there are others, particularly in urban areas where there is no GP hospital tradition, where such hospitals are unlikely to be practicable. Regional strategic plans and other development proposals show that in a substantial number of districts, health authorities see no alternative at present to the continuation or development of large single-specialty geriatric hospitals, sometimes combined with beds for the elderly severely mentally infirm often with clerical or medical assistance providing day to day care. In view of this situation further consideration is being given to future policy for longer-stay care for the elderly. Research is being undertaken into the possible development of a nursing home type of provision within the National Health Service.

Residential Accommodation

While increased emphasis is being placed on the provision of all kinds of domiciliary support and of sheltered housing for elderly people there will continue to be some who become unable to look after themselves in their own homes even with support, and for whom residential care will be necessary. The primary aim of residential care is to provide a setting within which elderly people who cannot continue to manage in their own homes may lead as normal a life as they are able to, maintaining individuality and dignity. It is therefore important that old people are not diminished in status, rights or privileges by taking up residence in homes. On admission to homes most residents are already very old and may have several disabilities. Most will, up to that time, have regard for themselves as responsible people able to order their own lives, albeit with the help of others. It is therefore important that within the home every encouragement is given for individuals to continue to live as independently as possible. It should also be the aim to ensure that the home is part of the local community with which residents can, as far as they wish, have links.

Residential care is an extension of community support but in changing his abode to a residential home an old person is in effect acknowledging the need for more assistance with the practicalities of everyday living than he can conveniently receive in his own home. However, residential homes are not nursing homes nor are they extensions of hospitals. In assuming the statutory responsibility of providing accommodation for an old person, a social services department also assumes responsibility for promoting that person's

welfare. The physical and mental well-being of residents requires that independence and satisfying activity are fostered among all those capable of undertaking and benefiting from them. Residents should therefore be involved as fully as possible in making choices which affect them, and be encouraged to contribute whenever feasible to their personal domestic arrangements such as making their own beds and tidying their rooms and contributing to other activities connected with the running of the home.

The role of residential care within the range of services for the elderly has undoubtedly shifted with the expansion of domiciliary services and sheltered housing. Changes in psychiatric practice and policy have led to a reduction in the number of elderly residents in psychiatric hospitals and this, together with the emphasis in modern geriatric medicine on active treatment and rehabilitation, has tended to place greater demands on residential homes for long-term care. Consequently residents are generally much frailer physically or mentally on admission than previously. Residential care is still often regarded by the community and some service providers as a "last resort" offering only custodial care with little regard for social rehabilitation. Although the provision of premises has had high priority in the programmes of social services departments the status of residential social work has been unduly low in relation to fieldwork services and professional activities in other agencies and settings. Furthermore, services for the elderly have not been accorded the priority afforded other client groups by trained staffing at residential or fieldwork settings in social services departments (11).

Although residential accommodation provides mainly long-term care, there is the small but steadily increasing use of residential homes to provide short-term care. In England the number of places rose from 21,000 in 1970 to 35,000 in 1976.

The National Assistance Act 1948 had as one of its main intentions the removal of the image of the workhouse and Poor Law Charity from publicly provided accommodation. It placed upon local authorities a duty to provide "residential accommodation for persons by reason of age, infirmity or any circumstances who are in need of care and attention which is not otherwise available to them". In developing this service the policy suggested for local authorities was to provide accommodation in small homes for about 30 to 35 persons and their initial plans were to include arrangements for the provision of such homes either by the acquisition and adaptation of suitable houses or, as far as was practicable, by new construction. The aim was gradually to close down large, obselete premises formerly used for Poor Law purposes, but it was recognised that pressure on existing accommodation and the heavy demand for residential care stimulated by the Act would require existing buildings to be retained for some years.

Local authorities were also given powers in section 26 of the National Assistance Act to provide residential accommodation in homes run by voluntary organisations. These powers were extended by section 44 of the Health Services and Public Health Act 1968 to include accommodation in homes run privately. This remains the present position: local authorities must provide residential accommodation of

one kind or another and may do so if they wish by sponsoring residents in voluntary and privately owned homes (12).

The first official information about the scale of provision of places in residential homes appeared in the Government Blue Book, "Health and Welfare - the Development of Community Care" (13) which was published in 1963. The existing provision in England and Wales varied, according to this report, from 8 to 25 places per thousand population aged 65 and over in the different local authority areas with an average of 16.1 places. Many of these places were located in former Poor Law institutions whose progressive replacement was recommended in the report. In language very reminiscent of that used in the Hospital Plan (14), with no reference to underlying research findings, the report stated "that in areas where the domiciliary services were well developed and the hospital services adequate, local authorities appear to be achieving appropriate provision with something in the range of 18 to 22 places for every 1,000 persons aged 65 and over." However, the interdependence of different services was stressed and the report went on to say that the right provision of residential accommodation would only be attained if the whole range of housing, health and welfare services on the one hand, and the hospital services on the other, made their proper contribution in co-operation with each other.

In June 1966 another report (15) on the development of community care suggested that knowledge was still too limited to enable standard ratios of places to population to be laid down and also suggested that local conditions must in any event call for different levels. This

report stressed the relationship between the hospital and welfare services in providing residential care and reference was made to Circular 18/65 (16) which outlined the division of functions between the services and sought close co-operation between them both in planning and in policies for admission. The report went on to say that "experience so far would suggest that most authorities may find a ratio of between 15 and 25 places per thousand population aged 65 and over appropriate to their areas."

The current guideline for the provision of local authority residential accommodation, first promulgated in Circular 35/72 (17), is 25 places per thousand population aged 65 and over, made up of local authority places and places sponsored in voluntary and privately run homes. The guideline was devised as one way in which a judgement could be reached about local achievement in a national context, and did not take into account the many local factors which might legitimately sway authorities to plan provision at variance with it. These might include the social economic and demographic make up of the area, the availability of voluntary and private sector residential accommodation, the extent of domiciliary health and social services provision and the availability of sheltered or other special housing. The guideline is now considered to be even less satisfactory since most elderly people are not admitted to residential care until they are well into their 70s or even older (18). It has nevertheless been restated in the Consultative Document (19), the Way Forward (20) and in Local Authority Circular (78) 6 (21). The guideline has been achieved by only some 10% of local authorities, and overall there is considerable variation in their levels of provision (22).

There are currently some 2,658 residential homes for the elderly run by local authorities in England, accommodating in 1981 about 108,000 residents at any one time. Homes run by voluntary organisations numbered about 1,100, and by private individuals about 2,500, and these accommodated respectively some 32,000 and 34,000 residents (mostly elderly). Some 14,000 elderly residents in voluntary homes and 2,000 in privately run homes were the responsibility of local authorities under the National Assistance Act.

For some years, the age on admission to residential care of elderly people has been rising. Townsend (23) found proportionately more new residents from the older age groups than would have been expected from the general population over 65 years. This tendency has since been confirmed by subsequent studies of new admissions, eg Brocklehurst et al (24) and of residents in situ, Wilkin and Jolley (25) and Dodd et al (26). In 1975/76 there were nearly 39,000 admissions to residential care on a permanent basis of persons aged 65 and over. Of these over 80% were aged 75 and over and nearly 34% 85 and over (27). Frailty, both physical and mental, generally increases with age and the pressure on residential places tends to ensure that only the very frail who can no longer manage on their own in the community, even with considerable support from the domiciliary health and personal social services, secure admission. This has continuing implications for residential care.

The Department's policy on the care of elderly people suffering from a mental infirmity envisages community or residential care as appropriate for those with mild dementia uncomplicated by other

serious physical illness. The increasing numbers of elderly residents suffering from some degree of mental infirmity present particular problems in residential homes. Their presence can disturb other residents and staff, both of whom may resent their behaviour, and local authorities sometimes house infirm residents in separate wings within ordinary homes or in completely separate homes. There is evidence that existing residents who develop mental infirmity may be better tolerated by their fellows than a newcomer with such disability. An increasing demand for residential care for the elderly mentally infirm is foreseen, and the implications for staffing levels and staff training are considerable.

Domiciliary Services

Throughout the United Kingdom approximately 94% of all elderly people live in private households in the community, including about 5% in sheltered housing. Their health services are mainly provided by the National Health Service primary health care team which includes the general practitioner, district nurse, health visitor and supporting staff, and by dentists, opticians, pharmacists and chiropodists. Social services are provided mainly by the local authority through locally based social services teams which might include social workers, home help organisers, mobility officers for the blind, advisers on technical aids and adaptations, and occupational therapists, and by some voluntary organisations particularly those with delegated responsibility for meals-on-wheels. Elderly people form a significant proportion of the workload of the domiciliary services and, for example, expenditure on the over-65 age group

represents about half the total expenditure on personal social services.

Many elderly people do not regularly receive the domiciliary health and social services and indeed have no need of them. In 1980, the General Household Survey shows that in a one-month reference period approximately 11% of people over the age of 65 use the chiropody service, 9% the home help service, 5% day centres, 6% the district nursing service, and 2% meals-on-wheels.

The current pattern of services for elderly people has been in existence for some considerable time, but the development of primary health care teams (since the mid-1960s) and the implementation in 1971 of Section 45 of the Health Services and Public Health Act 1968 which empowered local authorities to promote the welfare of old people, have provided important stimuli to the expansion of domiciliary provision.

The term primary health care refers to the first point of contact between a member of the public and the community-based health services. It is a personal service to people in their own homes, at the doctor's surgery, in clinics and in health centres. The aims of primary health care are:

a. The promotion of health in its broadest terms, through education, support and the encouragement of self-care.

b. The prevention of ill-health by prophylaxis, early diagnosis, education and advice on the value of early contact with the primary health care services.

c. The care, treatment and rehabilitation of those who are acutely or chronically ill.

d. The referral of patients to specialist services where necessary, and the provision of continuing care following specialist treatment.

Primary health care services are provided at present by virtue of the National Health Service Act 1977. They are delivered in 2 ways - by practitioners who enter into contracts for services with Family Practitioner Committees, and by other professional staff employed by Area Health Authorities. For the most part, the primary care services are conditioned by the level and type of patient demand, and by the individual professional decisions of those providing the services. Expenditure on the family practitioner services is related to the number of practitioners and the responsibilities and work they undertake. There is no pre-determined allocation of resources by area for these services.

Elderly people account for about 19% of GP consultations and people over the age of 75 have over 50% of their consultations at home compared with an average for the population as a whole of only about 17%. Family practitioners receive weighted capitation fees for patients over the ages of 65 and 75 in recognition of the greater

demand made on their services by elderly people and the more continuous attention required. About 18% of general practitioners practise from health centres which, although they make an important contribution to the development of primary care teamwork, are not always ideally suited to the requirements of elderly people who sometimes find them confusing and impersonal. The trend towards group practices incorporating, for example, supporting staff and appointments systems may lead to more effective working but can bewilder elderly people unless properly presented. A separate problem is that transport difficulties may arise when branch surgeries are closed.

Some general practices maintain age/sex registers which enable vulnerable elderly people to be kept under regular surveillance. The Royal College of General Practitioners encourages the keeping of such systems and has designed a suitable index card. Clerical support may be needed by the general practitioner in order to run some systems and the Health Department's ancillary staff reimbursement scheme allows 70% of the salary of secretarial help employed by a doctor to be reimbursed within certain limits.

Some 40% of cases dealt with by district nurses and about 13% of those of health visitors involve elderly people. One million four hundred and thirty seven thousand people who are treated by district nurses in 1981 compared with one million one hundred and twenty nine thousand six hundred in 1976 and about 70% of these people were treated in their own homes. A night nursing service is available in a number of districts. Health visitors saw 465,000 elderly people in 1981 compared with 531,000 in 1976.

Health visitors are state registered nurses who have undertaken an additional year's post-basic training following appropriate midwifery/obstetric experience. Their functions include the detection of ill health and the surveillance of high risk groups, the mobilisation of appropriate resources where necessary, the prevention of ill health and health teaching. They are essentially family visitors concerned with the health of the family as a whole as well as the health of each individual in the family. District nurses are state registered nurses or state enrolled nurses, who have received further training which prepares them to give skilled nursing to people living in the community (including residential homes). Despite the apparent differentiation of roles between these 2 groups of staff many common tasks are carried out. Whether these tasks are done by health visitors or district nurses, largely depends on the reasons for the initial referral. Both the health visiting and the district nursing services have responsibility to other groups such as young children and it has been argued (29) that health visitors should spend proportionately less time with elderly people and district nurses proportionately more.

The kind of care needed by some elderly people - for example help with bathing or cutting toenails - usually does not need to be done by highly-trained staff (and, indeed, it is often a misuse of resources if it is). Both the district nurses and health visitors have supporting staff. These include nursing auxiliaries who, with suitable supervision and in-service training, may be able to provide the care needed by many elderly people as well as advising on simple health education. The number of nursing auxiliaries who support district nurses increased from 2,079 in 1975 to 2,458 in 1976, an increase of 18%.

Elderly people at present receive free prescriptions when they reach pension age and these account for about 25% of all items prescribed on the National Health Service. NHS dental and optical treatment is free only if the elderly person has low income or is in hospital. Access to optical, dental and pharmaceutical services is not always easy for elderly people. In some areas NHS dental treatment is not readily available and the closure of pharmacies, about 325 in 1976 and 1977. can have serious effects on elderly people.

Under Section 45 of the Health Services and Public Health Act 1968 approval has been given to local authorities to make arrangements for any of the following purposes in order to meet the needs of elderly people:-

a. to provide meals and recreation in their homes and elsewhere;

b. to inform the elderly of services available to them and to identify elderly people in need of services;

c. to provide facilities or assistance in travelling to and from home for the purpose of participating in services provided by the authority or similar services;

d. to assist in finding suitable households for boarding elderly people;

e. to provide visiting and advisory services and social work support;

f. to provide practical assistance in the home, including assistance in the carrying out of works of adaptations or the provision of any additional facilities designed to secure greater safety, comfort or convenience;

g. to contribute to the cost of employing a warden or welfare functions in warden assisted housing schemes;

h. to provide warden services for occupiers of private housing.

The powers are exercisable by authorities with social service functions, that is Metropolitan District Councils, Non-Metropolitan County Councils, London Boroughs and the City of London. Quite separately Non-Metropolitan District Councils have powers under Section 31 of the National Assistance Act 1948 (as amended) to provide meals and recreation for old people in their own homes or elsewhere but information is not collected on the extent to which these powers are used. Elderly people may generally benefit fom Section 137 of the Local Government Act 1972 which gives local authorities power to incur expenditure that is in the interests of all or part of their area or some or all of its inhabitants up to the product of a 2p rate. Paragraph 3 (1) of Schedule 8 to the National Health Service Act 1977 imposes a duty on local social services authorities to provide, or arrange for the provision of, a home help service on the scale adequate for the needs of the area concerned and gives them discretionary powers to provide laundry services to households for which a home help service is being, or can be provided.

Aimed, as all social work is, at helping people solve their own personal and social problems, the same skills are needed for such work with old people as for any other age group. In addition to an ability to form a working relationship between the worker and the client, which is common to all who practise in health and personal social services, those specialising in work with the elderly need full understanding of the ageing process and the social and practical implications of it for the whole family if elderly people are to receive effective help through social work. Currently, assistant or trainee workers, sometimes supervised by trained staff, undertake most social work with elderly people. Skilled counselling may not therefore always be available to those having to make major decisions about changing lifestyles in old age (29).

Local authority home helps are mainly engaged for general household cleaning (sweeping, dusting but not spring cleaning), doing small personal laundry, shopping and preparing or cooking a meal. There has been a long-term shift in the distribution of home help services towards the elderly. In 1969, 83% of home help recipients were aged over 65 compared with 89% in 1979-80. The number of cases where a recipient is over 65 years has increased by 65% since 1969 compared with an increase of 10% for other clients. The number of elderly people receiving a home help during 1979-80 was 659,600 and the proportion of elderly people receiving home helps has increased from 6% to 9.4% between 1969 and 1979-80. There are, however, substantial variations in the rates of home help provision between authorities.

The Elderly at Home Survey (30) reveals that the greatest need for assistance among elderly people is for help with heavier tasks and with those tasks which involve some agility. There has been a tendency for the caring function of home helps to be emphasised in recent years compared with their purely domestic role and this may not necessarily match up with the requirements of elderly people themselves. An unknown number of elderly people obtained domestic help on a private basis but, even where this is possible at reasonable cost, the range of activities carried out is likely to be less than would be performed by a local authority home help.

The number of meals served by local authorities rose from 33 million in the year ending March 1974 to over 41 million in the year ending March 1977. Over 97% of people receiving meals are elderly people. Of the 41.4 million meals served in 1980-81, 27 million were served in people's homes (meals-on-wheels) and nearly 14.4 million elsewhere in places such as luncheon clubs and day centres. There is an increasing trend to serve meals in clubs and centres wherever possible with transport being arranged sometimes if necessary for those requiring it. Something like one half of all meals are served by volunteers with the Women's Voluntary Service being particularly active. The average number of meals served at home per recipient per week is 3 but there are wide local variations and only 4% of those receiving meals receive them on 6 or more days a week. The fact that the vast majority of recipients are not highly dependent on the service for a regular part of their weekly nourishment has led to some confusion about the objectives of the meal service. Increasing people's nutritional intake and providing social contact through the

regular delivery of meals or regular attendance at luncheon clubs are both important features of the service.

The purpose of day care is to provide social contact and stimulation, a change of environment, relief for those caring for elderly people, and their general focus for therapeutic activity. About 12% of elderly people go at least once a week to social centres run specially for elderly people. These centres include the day centres run by local authorities and a great variety of centres run by voluntary organisations ranging from elaborate purpose-built accommodation to High Street pop-ins. The number of local authority day centre places for elderly people has increased by over 50% since 1974 and there are now about 22,000 places available either in separate centres or in centres attached to residential homes. Additionally, up to 11,000 places are available in centres which cater for mixed client groups including elderly people. The provision of day care is patchy and urban areas are better served than rural.

Some authorities run such services as welfare rights bureaux, night sitting services, incontinent laundry services, street warden schemes, or provide alarm devices for use in elderly people's homes. No statistics are collected on such services and no guidance has been issued. Care attendant schemes, where paid "volunteers" provide a service to families caring for elderly relatives that involves duties somewhere between those of a home help and a nursing auxiliary, are being run on an experimental basis in some areas. Intensive domiciliary care, designed as a substitute for some types of hospital care, is being experimented with in some areas also.

Pattern of Service Use

In theory, the provision of health and personal social services is flexible, as the care or treatment provided is sensitive to individual circumstances and based on a professional judgement of need (or relative need) in the individual case. In general terms, frailty is more prevalent at older ages and because of this, service use is age-related. Table 3 shows how the percentage of elderly people visited by domiciliary services in a 6-month period is highest amongst the most elderly.

Table 3 Visits from domiciliary services categorised by age of recipient

Visits received from	% of elderly people visited in a 6 month period			
	All elderly	Age Group		
		65-74	75-84	85 and over
Doctor	33	27	47	50
Health Visitor	4	2	8	6
District Nurse	8	5	12	20
Home Help	9	4	16	27
Council Welfare Officer	5	3	5	8
Social Security Officer	6	5	8	11
Meals-on-wheels	3	1	5	11

Source: Elderly at Home Survey unpublished data

The Elderly at Home survey shows that physical old age in the sense that it is generally understood, does not begin at the age of 65 for most people. Nine tenths of the people interviewed who were between the ages of 65 and 74 were able to go out on their own without assistance, nearly half have no disabilities which limit their activities even to a minor extent, and 8 out of 10 assert that their general health is good. The only personal tasks which cause difficulty to more than a tiny number are bathing and cutting toenails. The same is true of domestic tasks apart from those which involve heavy work or climbing.

Although domiciliary services are used more intensively by the higher age groups within the elderly population, the larger numbers in the lower age groups mean that total service usage by the 65 to 74 age group remains significant. The Elderly at Home survey suggests that about 31% of visits made by domiciliary social services to elderly people go to the 65 to 74 years age group, 53% to the 75 to 84 years age group and 16% to the over 85s. 32% of those elderly people characterised as being severely restricted in their ability to perform household tasks receive domiciliary social services compared with 4% of those less restricted. Table 4 shows the percentage of bedfast and housebound elderly people who are visited by domiciliary services in a 6 month period.

Table 4 Visits from domiciliary services to bedfast and housebound elderly people.

Visits received from:	% visited in a 6 month period
Doctor	71
Health Visitor	22
District Nurse	37
Home Help	31
Council Welfare Officer	12
Social Security Officer	16
Meals-on-wheels	12

Source: Elderly at Home Survey

Over 4% of elderly people can be characterised as severely restricted with severe difficulties in personal tasks. Nearly half of these people receive neither health nor social domiciliary services.

It is difficult from survey material to make judgements about the extent of the unmet need for domiciliary services. For example, the Elderly at Home survey shows that just under 9% of elderly people are unable to cook a meal. But the great majority of these people have a main meal cooked for them by somebody else in the same household (eg a spouse) and it cannot be assumed that a meal-on-wheels is needed or

would even be welcomed. No guidance is issued by DHSS about the optimum pattern of visits to elderly people by statutory services, and differing local levels of provision would make the framing of such guidance difficult. There is difficulty in the identification of those in need so that services can be appropriately delivered. Early intervention by the Health and Social Services is desirable to reduce the likelihood of crisis and breakdown but it is always difficult to assess the cost effectiveness of services such as regular visiting of those who may on some criterion be considered "at risk". Particular groups at risk with high mortality incidence may be the newly bereaved, those recently discharged from hospital, those aged over 85 living alone, and those at risk of low body temperatures. Table 5 shows the percentage of elderly people living alone who are visited by domiciliary services in a 6 month period.

Table 5 Visits by services to elderly people living alone.

Visits received from:	% visited in a 6 month period
Doctor	28
Health Visitor	6
District Nurse	8
Home Help	19
Social Welfare Officer	6
Social Security Officer	9
Meals-on-wheels	6

Source: Elderly at Home Survey

Though the Secretary of State does have ultimate statutory powers to direct health authorities and remedy gross default by local authorities, the statutory tolerances for the provision of particular services are wide and the DHSS must rely primarily on guidance and persuasion, following consultation, for disseminating national priorities and policies. Guidance on these priorities and policies needs to reflect the levels of central government financial support for health and local authorities, and the claims on available resources of competing services. Implementation of the Department's policy on domiciliary care rests with local statutory authorities and decisions taken locally may sometimes reflect different priorities from those of the Secretary of State for Social Services.

The development of domiciliary services over the years has relied largely on professional judgements and has been influenced by demands from pressure groups. Norms and guidelines have been issued by DHSS for most of the services but these were not drawn up on any scientific basis either in relation to the individual services themselves or as part of a co-ordinated pattern of deployment for all services for the elderly. However, because of the discretionary nature of domiciliary services, and in the absence of central guidance, differing patterns of service provision have grown up in different areas. Local needs vary and demographic, social, economic and political factors are not constant between authorities. There are wide variations, for example, in expenditure per head of the elderly population by local authorities on the personal social services. The difference between the lowest spending authority and the highest spending authority is over 500%. There are higher levels of provision for most services in

urban areas and this is particularly marked for home helps and meals-on-wheels. It is notable that some of the low-spending authorities cover areas to which substantial numbers of people retire and where some of the greatest concentrations of elderly people live.

Recent Policy Developments

In the late 50s and 60s "community care" was seen by the Ministry of Health as a means of relieving pressure on hospitals. However, by the late 60s, the main focus had become how to limit the demand from elderly people for local authority residential accommodation. Means (31) suggests that this could only be achieved by an extension of certain domiciliary services which could no longer be entrusted to the voluntary agencies. He further suggests that "A Happier Old Age" (32) makes it clear that the DHSS is now determined to reduce pressure for domiciliary services and this is to be carried out through an extension of family and community support. Such support cannot be left to the altruistic instincts of relatives and neighbours but should rather be encouraged by the state through such developments as Good Neighbour Campaigns, Street Warden Schemes and Granny Fostering Projects.

This trend in state policy towards elderly people has been further confirmed by 2 recent Government publications, "Growing Older" (33) and "Care in Action" (34). The first is the White Paper which is based on the discussions and submissions encouraged by "A Happier Old Age". The main argument is that:-

"Whatever level of public expenditure proves practicable and however it is distributed, the primary sources of support and care for elderly people are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable. It is the role of public authorities to sustain and, where necessary, develop - but never to displace - support and care. Care in the community must increasingly mean by the community".

"Care in Action" pursued a similar message. This priorities document - now called the handbook of policies and priorities for the Health and Personal Social Services in England - stressed that restrictions on public expenditure made it essential to be careful in the allocation of domiciliary services. It is argued that DHSS research "suggests that the development of community services has not so far been specifically directed at those groups of people who require a particular intensive degree of support if they are not to be taken into long-term care" and this situation is seen as requiring speedy rectification. The needs of those less "at risk" can be met by informal carers and the voluntary agencies so long as these receive the necessary professional advice and financial support from local authorities.

In July 1981 the DHSS issued a Consultative Document on moving resources for care in England (35). This Paper had its origins in the publication, "Care in Action", and was drawn up after informal discussion with interested people in the Health and Personal Social Services field. It explored a wide range of possible approaches and the covering circular suggested that Ministers were not committed to any particular approach.

In September of the same year the DHSS published studies on what were described as 3 key areas of the National Health Service and the Personal Social Services - the acute hospital sector, the care of elderly people in hospital and the shift from institutions to care for people in the community (36, 37, 38). At the time of their publication the then Junior Health Minister said:-

"Each study deals with trends over the last few years in 3 key areas of Health and Personal Social Service provision. The studies do not attempt to set out Departmental policy: their function is to raise issues, set discussion going and stimulate new ideas". However, the outcome of the consultations generated by these initiatives by Government was that in March 1983 a Circular was issued to Health Authorities, Local Authorities and the voluntary organisations (39). Announcing the issue of the Circular in the House of Commons the Secretary of State for Social Services said:-

"The Circular gives Health and local authorities the go-ahead to set up joint projects for moving people out of long-stay hospitals and into community care. The most important change is that for the first time every health authority will be able to offer to local authorities and the voluntary organisations continuing payments for as long as necessary to provide for people moving out of hospitals into community care. .....this goes much further than the so-called joint finance arrangements which will provide support finance only for a period. Most people responsible for the care of mentally ill, mentally handicapped, elderly and disabled people agree with the government that there are still far too many people unnecessarily kept in hospital for long periods simply because facilities are not available to care for them in the community." This is the most recent statement of Government policy on the care of the elderly.

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CHAPTER 4

LEGISLATION, POLICY AND POLICY OUTCOMES IN NORTHERN IRELAND

LEGISLATION

Any comparison of legislation and policy between Northern Ireland and the rest of the United Kingdom in the Health and Personal Social Services field must have regard to the Social Services Agreement which was incorporated in Acts of Parliament passed by the 2 legislatures in Belfast and Westminster. The primary purpose of the Agreement is to make provision for adjustments in the financial relations between the 2 Exchequers if expenditure on Social Services in Northern Ireland exceeds or falls below a certain proportion of expenditure on such services in Great Britain. Commenting on the Agreement the Tanner Report (1) stated "it has profound influence on the standard and indeed upon the organisation of the Health Service in Northern Ireland."

As part of the Agreement, the Government of Northern Ireland undertook subject to such differences as may arise from time to time between the methods of administration in Great Britain and Northern Ireland of the services covered by the agreement -

"to keep the scale and standard of comprehensive health services in Northern Ireland in general conformity with the scale and standard of such services in Great Britain".

Therefore while the undertaking does not require the Government of Northern Ireland to copy the details of organisation in Great Britain in all instances it clearly prevents any radical departure from the level of provision in Great Britain.

Following the publication of the Report of the Select Committee on Health Services in Northern Ireland (2), 3 major Acts were passed by the Northern Ireland Parliament which provided the foundation of the current services. These were:

- Public Health and Local Government (Administrative Provisions) Act (Northern Ireland) 1946;

- Health Services Act (Northern Ireland) 1948; and

- Welfare Services Act (Northern Ireland) 1949.

The Public Health and Local Government (Administrative Provisions) Act (Northern Ireland) 1946 established the county and county borough councils as health authorities and welfare authorities. It made provision for the performance by them of certain functions relating to public health and social welfare, for the appointment of medical officers, for the abolition of the boards of guardians and for the amendment of the law relating to public health and poor relief.

The Health Services act (Northern Ireland) 1948 produced the service in Northern Ireland which closely followed the provision in Great Britain. Under Section 1 the then Ministry of Health and Local

Government was to promote and secure:

- improvement in the physical and mental health of those people [of Northern Ireland];

- the prevention, diagnosis and treatment of illness; and

- the ascertainment and prevention of mental deficiency and the care, supervision, training and occupation of mental defectives.

Section 43 of this Act was also similar to section 29 of the Great Britain National Health Service Act 1946 in that it made provision for local health authorities to make arrangments for a domestic help service for the same range of specified groups.

The Welfare Services Act (Northern Ireland) 1949 contained provisions which closely followed those in Part III of the National Assistance Act 1948 in Great Britain. The introduction to the Act stated that it was "an act to substitute for the existing poor law relating to work-house accommodation and relief provisions requiring welfare authorities to provide residential and other accommodation for certain persons in need thereof; ..... to make futher provision for the welfare of handicapped, sick and ageing persons ...." However, in addition to these provisions welfare authorities were also permitted to make arrangements "for providing domestic help for any person who, being aged or handicapped within the meaning of sub-section (1) of section 14 of this Act, lives either alone or in circumstances in which proper care and attention would but for such help not be

available to him." Thus both health and welfare authorities were able to provide this domiciliary service. This remained the situation until 1954 when section 43 of the Health Services Act (Northern Ireland) 1948 was repealed by the Welfare Services Act (Northern Ireland) 1954. The arrangements for the provision of a domestic help service were consolidated and responsibility placed on the welfare authorities. The National Assistance Act for Northern Ireland had been passed in 1948 but his was more limited in scope than the corresponding Act for Great Britain as it dealt mainly with the creation of the National Assistance Board.

No further major legislative change was made until 1961 when the Welfare Services Act (Northern Ireland) authorised welfare authorities to expand the range of services available to the aged by the provision of meals and recreational facilities. Section 33 of the Health Services (Amendment) Act (Northern Ireland) 1969 gave local authorities in Northern Ireland similar powers to those contained in the Health Services and Public Health Act of 1968, ie to promote the welfare of the elderly. In 1971 a Welfare Services Act (Northern Ireland) was enacted to consolidate earlier legislation and authorise the provision of a laundry service.

In 1972 the Health and Personal Social Services Order (Northern Ireland) 1972 repealed the whole of the 1969 and 1972 Health Services Acts and virtually all of the Welfare Services Act (Northern Ireland) 1971. The Order did not seek to make any widespread changes in the range of services but provided a new administrative structure for the health and personal social services in Northern Ireland. Under

Article 4 of the Order the Ministry (now the Department) has a duty -

"(a) to provide or secure the provision of integrated health services in Northern Ireland designed to promote the physical and mental health of the people of Northern Ireland through the prevention, diagnosis and treatment of illness;

(b) to provide or secure the provision of integrated personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland;

And the Ministry shall so discharge its duty as to secure the effective co-ordination of health and personal social services."

Finally one further piece of legislation has a bearing on the provision of the services. The Chronically Sick and Disabled Persons (Northern Ireland) Act 1978, which is similar to the Great Britain Act of the same name passed in 1970, authorises the provision of a wide range of domiciliary and day care services.

Policy

The "Strategy for the Development of Health and Personal Social Services in Northern Ireland" published in November 1975 (3) laid the guidelines for future development of all services by analysing present trends and by indicating long-term aims and priorities. The paper also stressed the importance of systematic planning at both regional and area level. Such planning was seen to relate not only to a

particular service such as hospitals in a given area but to the needs of and services required for specific groups of people such as the elderly in a given area. The latter process, planning for a particular patient/client group, constitutes a programme of care and as such involves the utilisation of total resources - staff, buildings and equipment - in an agreed operational policy for the defined group.

The overall objectives for the health and personal social services are "to promote, having regard as appropriate to considerations of parity with Great Britain, the health and social welfare of the people of Northern Ireland through high quality and cost effective health and personal services, provided on a co-ordinated and accessible basis and delivered in a manner acceptable to individuals and communities." Within this overall objective the objectives of a programme of care for the elderly have been defined as follows:

- to promote the health and social well being of the elderly by health education and other preventive measures; to maintain the independence of the elderly in the community at the highest possible level;

- to provide, for those who can no longer continue in their own home, alternative accommodation which will cater for the varying degrees of dependence (ie loss of independence);

- to provide care in day centres and investigation, treatment and care in day hospitals;

- to provide in-patient hospital services to allow for assessment, treatment, rehabilitation and continuing care;

- to ensure that residents/patients are not admitted to a higher dependency unit than their condition requires and that there is sufficient flexibility in the system to ensure that patients are maintained at the appropriate levels of care."

Hospital Services

The basis of the current pattern of hospital services for the elderly is contained in the 1966 Memorandum on the Development of Services for the Elderly (4). The memorandum noted that in 1964 there were 1,610 beds for old people (geriatric beds) in general hospitals. These represented 1.1 beds per thousand total population. At the same time there were 1,573 long- stay patients over the age of 65 in psychiatric hospitals representing a ratio of 1.1 per thousand total population.

As a result of the consideration of 2 reports (5) (6) and of the situation in the rest of the UK the following summary was contained in the memorandum.

1. the present total provision of hospital beds in Northern Ireland amounts to 2.2 beds per thousand to population, divided evenly between general and psychiatric hospitals;

2. the need for geriatric beds in general hospitals has been assessed at 1.5 per thousand population compared with 1.1 at present;

3. the need for long-stay "psychogeriatric" beds for the elderly mentally infirm have been assessed at 1.1 per thousand population; This is in fact the present ratio with psychiatric hospitals and 0.5 in general hospitals in association with the geriatric wards;

4. in combination, these assessments seem to produce an over estimate of needs compared with the proposed provision elsewhere in the United Kingdom, more particulaly in England and Wales, and with what is known about present and prospective developments in Northern Ireland;

5. It is suggested that the immediate target for hospital provision should be 1.5 beds per thousand population for geriatric purposes in general hospitals, including the elderly confused patients. The long-term target for all purposes, including patients in psychiatric care, lies between 2 and 2.6 per thousand population;

6. These targets are being taken into account in the preparation of the Hospital Plan for Northern Ireland.

The Hospital Plan (7) reiterated the planning norm and suggested that a somewhat higher ratio might be needed in the longer-term. As regards to beds for mental illness the plan noted that the number of beds required for mental illness in England and Wales was expected to decline from 3.3 per thousand total population to 1.8 per thousand total population by 1975. In Northern Ireland there were 6,220 beds

available for mental illness, a ratio of 4.24 beds per thousand total population, which was appreciably higher than the existing ratio in England. However, some 630 beds were occupied by mentally sub-normal patients and the ratio of beds in use for mental illness was 3.8 per thousand population. Therefore having regard to the further development of community care for the mentally ill and the fact that some elderly patients in psychiatric hospitals could be accommodated in the geriatric wards of the general hospitals if these were expanded, a ratio of 3.5 psychiatric beds per thousand total population was considered adequate for 1975. Some 5 years later the Second Review of the Hospital Plan (8) was published and was less than optimistic about the success of community care for the elderly as evidenced by the following extract -

"the hope has always been entertained that the gradual improvement in provision for care in the community would reduce the demand for hospital beds and would, in due course, make possible a reduction in the planning ratios of hospital beds per thousand population. While there has been a steady growth and improvement in community care since 1968 - as evidenced by a 10% increase in the number of staff employed by local health and welfare authorities and by the building of 21 new health centres and the provision of 14 residential homes for old people - there is yet no evidence to suggest that it would be feasible to reduce the hospital bed ratios proposed in the 1966 Hospital Plan and confirmed in the 1968 review. On the contrary, in the case of some specialities, notably geriatrics and special care, experience has indicated the need for an upward revision."

The review confirmed a new ratio of 1.65 beds per thousand population for geriatrics (ie the equivalent of 15 beds per thousand persons over 65) and was emphatic about the responsibility for care of some confused elderly people.

"There has been ample evidence for some time that the care of confused elderly patients with a physical handicap and with little prospect of recovery has become a most pressing problem in the care of the elderly. The proper care of such patients is in many cases so far beyond the resources of the community services that admission to hospitals staffed and equipped to cope with their special needs is the only acceptable answer. Suitable accommodation for such patients is limited, both in psychiatric hospitals and in geriatric units at general hospitals. It is clear that the major contribution to the solution of the problem will be a substantial increase in the number of geriatric beds in general hospitals and account is taken of this need in the building programme outlined in Chapter 4. There must at the same time be acceptance of consultants in charge of these beds that for such patients there is in most cases no satisfactory alternative to hospital care."

There was no change proposed for the ratio of psychiatric hospital beds, 3.5 per thousand population, established in 1966.

After re-organisation of the health and personal social services in 1973 the Department issued the planning guidelines to Health and Social Services Boards which confirmed the earlier ratio for geriatric beds. In addition, however, the Department stated that the scale of

provision for psychiatry should take account of the 3 main groups of elderly patients:

- the ageing long-stay population in psychiatric hospitals;

- the elderly with functional mental- illness; and

- those with senile dementia.

This third group had been the subject of a recent survey in Belfast (9) which showed that there was a significant number in this category who were classified by psychiatrists as being in need of psychiatric hospital care. Consequently it was proposed to adopt a ratio of 2.5/3 hospital beds per thousand population over 65 for those confused elderly patients whose needs, whilst not warranting admission to an acute psychiatric unit, cannot readily be met in a general hospital.

In 1975 the Department published a Programme of Care for the Elderly (10). This paper noted that the target scale of provision, 15 beds per thousand of the elderly population for assessment, rehabilitation and continuing care would have been attained by 1980. However, it was noted that not all the beds were designated as geriatric beds and not all were under the control of a geriatrician. The paper also stated that there was a need to examine the overall provision of psychiatric services in Northern Ireland and to have special regard to the problems of the elderly in psychiatric hospitals.

Tables 1 and 2 below show the number of geriatric beds available against the planning norms and beds in psychiatric hospitals.

TABLE 1

Available Geriatric Hospital Beds

	Geriatric Hospital Beds (15 per 1,000 elderly)			Psychogeriatric Hospital Beds (2.5/3 per 1,000 elderly)		
	Available	Target 1980	Shortage or Surplus	Available	Target 1980	Shortage or Surplus
Northern	586	568	+ 18	16	95/112	- 79/96
Southern	500	457	+ 43	Nil	75/92	- 75/92
Eastern	1288	1341	- 53	Nil	223/267	- 223/267
Western	418	390	+ 28	Nil	65/78	- 65/78
Total NI	2792	2756	+ 36	16	458/549	- 442/533

TABLE 2

Beds in Psychiatric Hospitals

Hospital	Geriatric Beds	Geriatric Beds per 1,000 of catchment Population	Total Psychiatric Beds	Total psychiatric beds per 1,000 of the catchment population
Downshire	363	1.16	916	2.94
Gransha	156	0.85	666	3.64
Holywell	218	0.16	634	1.78
Purdysburn	432	1.91	1170	3.23
St Lukes	284	1.52	571	4.26
Tyrone and Fermanagh	219	1.16	914	4.84
Other Units	-	-	104	-
Total	1592	1.54	4975	3.24

Finally, a recent report (11) shows the current state of bed provision for the elderly and the usage of other beds by elderly persons. The report notes that the uptake by the elderly of acute hospital services, particularly in-patient services, is high. In this context, the report states that acute bed provision in Northern Ireland compares favourably with that which obtains elsewhere in the United Kingdom. See Table 3 below.

TABLE 3

Average Daily Available Beds per 1,000 Population* (1977)

Country	Acute** Specialities	Medical	Geriatric	Surgical	Psychiatric	All Specialities
England	2.9	1.1	8.3	1.7	3.1	8.1
Wales	3.2	1.3	9.8	1.9	2.9	8.7
Scotland	3.5	1.4	13.3	2.1	4.7	11.4
N Ireland	4.2	2.0	13.8	1.9	4.2	11.1

* Total populations are used except in the case of geriatrics where the ratios relate to the population over 65 years old.

** All medical and surgical specialties, gynaecology and pre-convalescent departments.

Source: Regional Statistics (1980 Edition) HMSO.

It will be seen that in relation to population Northern Ireland has in the acute specialities a ratio of beds 45% greater than England, 31% greater than Wales and 20% greater than Scotland. In other specialities the country also has the best ratio except for surgery and psychiatry in relation to Scotland.

The report noted that the present designated geriatric bed position in Northern Ireland is slightly over the guideline of 15 beds per thousand population over 65 years old but suggested that a substantial number are in unsatisfactory accommodation. While acknowledging that the provision in Northern Ireland compared favourably with England and Wales (8.4 beds per thousand population over 65 years old) the report suggested that straight statistical comparisons might not be accurate as a number of factors have to be taken into account. These were listed as age structure of the elderly population, social conditions, primary care services available, level of other community services, the number of residential, day hospital and day care places provided, availability of accommodation for elderly patients with mental disability, and the contribution of the voluntary and the private sectors. Concern was expressed about the fact that there were only 8 beds for elderly demented patients outside psychiatric hospitals.

Residential Care

A circular letter (12) issued in January 1949 outlined the responsibilities of the new welfare authorities in undertaking the task of providing residential accommodation for elderly people. Among the issues considered in this circular were the types and management of homes and the selection of residents. Paragraph 25 of the circular stated that "it is not part of welfare committees' responsibility to provide hospital and specialist services or anything analogous to them; committees were definitely precluded by the Act from doing so. Nevertheless some of their work takes them certain distance in the direction of medical care; for example, in any home - as in any

family - there will be occasional sickness and committees must be prepared to have a sick person tended as he would be in his own home - perhaps in his own bed or in a special sick room. The resident's doctor would come in and if necessary a nurse would call."
Paragraph 26 to 29 of this circular are repeated below as they formed the basis of policy on residential care for the elderly for the following 3 decades and even now the issues discussed are still apposite.

"26. Whether infirm people should be admitted at all to a welfare committee home; whether a healthy old person on becoming infirm should be allowed to stay on in a home; whether the hospital should take him in as a patient; whether the hospital should discharge infirm patients for whom they can no longer usefully provide specialist medical and nursing care; whether once discharged from hospital such a person should ever be re-admitted for the same or any other complaint; these are all amongst the most complex social problems in this whole field, and they admit of no one simple answer.

27. Hospital beds are scarce and beds for long stay elderly patients are at least as scarce as any other. It is therefore in the interests of good hospital management to make sure that no bed is occupied by any person for whom specialist medical or nursing care is no longer recommended; and in deciding any individual case the final word must rest with the medical officer of the hospital. That principle must be accepted on all sides but in stating it the Ministry is placing its reliance on the Northern

Ireland Hospitals Authority to see to it that no person needing hospital treatment is refused admission, that no patient is discharged who still needs specialist medical or nursing care and that every effort is made (a) to develop geriatric services and with them the skilled investigation of long stay patients in every hospital and (b) to provide or set aside suitable beds for those patients who though not needing specialist medical care do require constant nursing attention which could not reasonably be given to them in their own homes or in a residential home or hostel.

28. If the Hospitals Authority contribute in this way, it is clear that Welfare Committees must also go some distance towards solving the problem from their side. A beginning could be made by the setting up of special homes designed to cater for persons of this type; they would be residential homes but so arranged that residents could, if necessary, spend some of their time in bed, if regular general practitioner medical attention was available, and there was at least one experienced nurse on the staff and above all that the home was managed in close co-operation with "even though far removed from" a hospital with special accommodation for old people.

29. Another step would be for welfare committees to arrange with a hospital or hospitals for elderly patients discharged and with no one to look after them to be taken into their homes on condition that the hospital gave special consideration to residents recommended for hospital treatment by welfare committees."

The policies outlined in this circular were clarified and emphasised in another circular issued almost 10 years later in August 1958 (13) which set out the division of responsibility between the welfare authorities and hospital authority for the residential care of the aged and particularly of infirm old people. This division of responsibility had been introduced in Great Britain and was defined as follows:

"Welfare Authorities
Apart from the active elderly person who is in need of residential care and who is clearly the responsibility of the welfare authority, the latter's responsibility also extends to the following:

1. care of the otherwise active resident in a welfare home during minor illnesses which may well involve a short period in bed;

2. care of the infirm (including the senile) who may need help in dressing, toilet etc and may need to live on the ground floor because they cannot manage stairs and may spend part of the day in bed (or longer periods in bad weather);

3. care of those elderly persons in a welfare home who have to take to bed and are not expected to live more than a few weeks (or exceptionally months) and who would, if in their own homes, stay there because they cannot benefit from treatment or nursing care beyond what can be given at home, and whose removal to hospital away from their familiar surroundings and attendances would be felt to be inhumane.

It is not regarded as the responsibility of the welfare authority to give prolonged nursing care to the bedfast (except those in (3) above, nor as desirable that separate "infirmary wards" should be created in large homes in which patients from other homes would be concentrated.

Hospitals Authority

Apart from the acute sick and others needing active treatment who are clearly the responsibility of the Hospitals Authority, the latters responsibility also extends to the following:

1. care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years;

2. convalescent care of the elderly sick who have completed active treatment but who are not yet ready for discharge to their own homes or to welfare homes;

3. care of the senile confused or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home".

The circulars of 1948 and 1958 shaped the pattern of residential care until 1973 when the latter was cancelled. The latest official statement on the role of residential care is to be found in the circular "Residential Homes for the Elderly - Arrangements for Health

Care" (14). Paragraph 7 of this circular states "residential homes are not nursing homes or hospitals but are primarily a means of providing a greater degree of support for those elderly people no longer able to cope with the practicalities of living in their own homes even with the help of the domiciliary services. The care provided is a limit to that appropriate to a residential setting and is broadly equivalent to what might be provided by a competent and a caring relative able to respond to emotional as well as physical needs. It includes, for instance, help with washing, bathing, dressing, assistance with toilet needs, the administration of medicines and, when a resident falls sick, the kind of attention someone would receive in their own home from a nurse member of the primary health care team or a caring relative under guidance of the general practitioner."

The first planning guidelines for residential accommodation in Northern Ireland were contained in a memorandum (15) issued in 1966 by the Ministry of Health and Social Services. The memorandum recorded that in December 1965 the total number of places in welfare authority and voluntary homes in Northern Ireland was 609 and 1043 respectively giving a total of 2652 places. This was equivalent to 17.8 places per thousand population over 65 years. The local situation was compared with that in England and Wales and account taken of a report on geriatric services (16). It was concluded that "in general, therefore, a reasonable measure of agreement on the present needs emerges, and a provisional standard of 20 places per thousand elderly population has accordingly been adopted for Northern Ireland". It is also worth noting some important caveats to this planning guideline

which were also contained in the memorandum:

a. some voluntary homes cater largely for healthy and ambulant old people and are unwilling or unable to accept people suffering from any pronounced degree of infirmity;

b. .....at the end of 1965 12.8% of welfare authority home places were occupied by people under 65;

c. some existing homes may need replacement;

d. some homes are overcrowded;

e. urgent and substantial waiting lists exist particularly in the Belfast area;

f. there is a shortage of special housing;

g. .....a proportion of the elderly patients at present accommodated in hospitals could be cared for in welfare homes if places were available for them.

This guideline remained in operation until 1970 when the Ministry adopted the Scottish figure of 25 places per thousand (17). This was reaffirmed in 1974 and a guideline of 3 places per thousand aged 65 and over was adopted for "mentally confused elderly persons". Similar advice has been re-stated recently in a planning circular (18) issued to Health and Social Services Board by the Department in 1980. Boards

were advised that the guidelines should not be regarded as inflexible targets but should be used judiciously in the planning of services to meet the varying needs and priorities of individual areas over the long-term.

At present there is accommodation for some 3,320 person in 78 statutory residential homes, 54 of which are purpose-built. This total includes 28 homes built in the last 8 years which provide around 1,200 places. Four of the homes provide short stay holiday accommodation for 41 people.

There are 5 statutory residential homes specifically designed for elderly people who are mentally confused: they provide 161 places, including 5 short stay places. Two additional homes are nearing completion and will accommodate a further 60 residents. Provision for this client group falls far short of need. There are 36 homes run by voluntary organisations and 12 homes run by private individuals accommodating some 1,290 and 156 elderly persons respectively. Approximately 600 persons are maintained by Health and Social Services Boards in voluntary and private homes. In addition there are 52 homes run by Abbeyfield Societies which accommodate 339 elderly persons.

As has been noted earlier the age on admission to residential care of elderly people has been rising in Northern Ireland. In 1976 it was reported (19) that of the then current population in Boards' homes 60% were over 75 on admission and 17% over 85 on admission. Frailty, both physical and mental, generally increases with age and the pressure on

residential places tends to ensure that only the very frail who can no longer manage on their own in the community, even with considerable support from the domiciliary health and personal social services, secure admission.

Most residential homes have among their residents elderly people whose behaviour shows confusion of mind (see Table 4) and while the problem of providing residential care for confused elderly people has attracted a great deal of attention in recent years there have always been a considerable number of elderly mentally disordered in residential accommodation.

Table 4

Levels of Functioning of Elderly People in Residential Homes - Comparison of Different Studies. (20)

Study	Date of Study	% Lucid	% Severely Confused
Carstairs and Morrison (Scotland)	1969	58	6
DHSS (England and Wales)	1970	57	12
Kimbell and Townsend (Cheshire)	1973	42	16
Sheffield Internal Enquiry	1975	45	-
Salop Internal Enquiry	1976	39	9
Townsend (Northern Ireland)	1976	49	10
Masiah, Smith and Jolley (Manchester)	1976	56	14
Avon Internal Enquiry	1977	47	16
Harringay Social Services Department	1977	39	20
Wilkin and Jolley (Manchester)	1978	49	13
McLauchlan (Tameside)	1978	46	14

Domiciliary Services

While the main emphasis in early post-war welfare legislation in Great Britain appears to have been on the provision of residential accommodation central government policy in Northern Ireland has frequently advocated the merits of domiciliary care. As early as 1949 the following advice (21) was being given to the newly- constituted welfare authorities.

"The principle aim is not to admit as many persons as possible to homes or hostel; the opposite might almost be adopted as the primary objective, mainly to do everything possible to see that few people have to be offered accommodation. In other words the ordinary community is the place in which people - even when in misfortune or when disabled or infirm or old - should live their lives, contributing what they can to that community through their work and their fellowship and relying on that community normally for help in case of need, and as the natural unit of this community is the family, the approach of the Welfare State ought to be to the family and to the effort made to employ the resources of the family to the full - physical, mental and spiritual". The views were confirmed and reiterated in a circular (22) issued in 1958 which stated "the development of domiciliary services, and in particular of the home help service has brought about a significant change of emphasis in the care of old people. The primary aim of Welfare Authorities is now to look after old people in their own homes wherever possible. The Ministry endorses this policy and welcomes the development of services for this purpose."

As in Great Britain the development of the domiciliary services has relied largely on professional judgements and has been influenced by demand from pressure groups. Few guidelines for the provision of services existed but in 1974 the Department issued target scales of provision for a variety of services. These were intended as an aid to planning the development of services as programmes of care. Boards were asked to expand their meal services to 200 per week per thousand elderly, either delivered through the meals-on-wheels scheme or provided in day centres, or lunch clubs. In addition Boards were asked to plan day centres on the basis of multi-purpose usage, ie by the elderly, the physically handicapped and the mentally disordered. The scale of provision recommended was 140 places per 100,000 population made up of 50 places for the elderly, 30 places for the physically handicapped and 60 places for the mentally disordered.

The following paragraphs set out the current state of a range of community services available to elderly people in Northern Ireland.

General Medical Practitioner Services

Because the vast majority of elderly people live at home and have their illnesses treated there the family doctor is the person who deals, in the first instance, with most of the health problems. Although statistics of home visits to the elderly and of patient visits to the surgery are not recorded for Northern Ireland, a survey of the elderly (23) indicated that about 35% had seen their doctor within the last 4 weeks, and that 69% had seen him within the last 6 months. This survey showed that those people who considered their

health to be poor and those who were very old saw their doctor more frequently than other groups. In Northern Ireland at 31 December 1979 there were 66 health centres providing for 415 general practitioners, 55% of the total number of practitioners in the Province (24).

Nursing Services

Statistics show that around 75% of district nurse visiting is to sick elderly people. Although health visitors make a sizeable number of visits to elderly people each year, only a small percentage of their time is devoted to this work. Statistics for district nurse and health visitor visiting to the elderly for the years 1976-1978 show that district nurse visits rose from around 1,084,900 (74% of district nurse visits) to 1,161,900 (76%) and health visitor visits decreased from around 75,700 (11% of all visits by health visitors) to 71,200. The survey mentioned earlier showed that about 88% of the elderly had never been visited by the district nurse and 92% had never been visited by the health visitor.

Social Work Services

No statistics are available for either social worker or social work assistant visits to the elderly but it is known that social services contact with the elderly at home is provided mainly by social work assistants, usually as the result of a request for a social service, rather than for social work. Some earlier work by this author showed that social workers were in contact with 23 elderly people (0.4%) and social work assistants with 1,699 elderly people (29.6%) out of an

estimated total of 5,738 people aged 75 and over living in a particular district. (25)

Home Help Service

It has been accepted for many years that the home help service makes a major contribution to the overall development of community care by enabling people to remain in their own homes for as long as possible and thus avoids or delays the need for admission to hospitals or residential accommodation. Prior to the re-organisation of the health and personal social service in 1973 each County and County Borough Welfare Committee operated a home help service in its own area and the standard of service, rates of pay, etc for home helps varied considerably through the Province. Following reorganisation there was a rapid development in the extent and cost of the service and in 1974, following consultation with Boards, the Department issued guidelines for the service (26). In 1980 the Department issued a new model scheme for the provision of the home help service and at this time suggested the following criteria for the provision of service.

"Home help may be provided for families and individuals who need help with essential family and household activities such as caring for children, training, laundry, preparing and cooking food, shopping and attending to heating systems, because of the incapacity, over-loading or absence of the person normally undertaking family and household duties and where alternative help is not forthcoming.

Home help may be provided also for individuals who need help with

personal care tasks such as dressing and undressing, washing and bathing, shaving and hairdressing, personal hygiene and toileting and this might be undertaken by a competent and caring relative where he/she is available." Priority groups were also established and the circular setting out the new model scheme suggested that the priority for service should be given "to families and individuals for whom alternative arrangements would have to be made if the home help service was not provided to meet urgent need or to prevent deterioration in physical and/or social circumstances."

In England the Department of Health and Social Security has suggested a guideline of 12 full-time home helps per thousand elderly. Local authorities vary greatly in the extent to which they meet the 12 per thousand guideline. Some exceed it but many fall far short. The national average is little over half the recommended figure (27). In Northern Ireland the rate of provision at 30 September 1983 was 19.4 home helps per thousand population over 65. Despite the existence of a model scheme prepared by the Department there is considerable variation in the level of provision between Boards and an even more marked difference in the level of provision between districts of Boards. The level of provision for each of the 4 Health and Social Services Boards is as follows:-

Northern 14.8 per thousand, Eastern 19 per thousand, Southern 25. per thousand and Western 21.5 per thousand. The 3 districts having the lowest level of provision are Antrim and Ballymena (Northern Board) 9.5; North Down and Ards (Eastern Board) 11.1 and East Belfast and Castlereagh (Eastern Board) 12.3. The 3 districts having the highest level of provision are Armagh and Dungannon (Southern Board) 26.1,

North and West Belfast (Eastern Board) 29.5 and Newry and Mourne (Southern Board) 30.1.

The net expenditure on the home help service has increased from £8.4m in the 1978, 1979 financial year to £16m in 1982/83 ie an increase of £7.6m (90%). Expressed in constant terms (1978/79 prices by reference to movement in the Retail Price Index) the expenditure on the service shows an increase of 17% in real terms between 1978/79 and 1982/83. During the same period there has been only a 5% increase in the average number of home helps employed by Boards and a 21% increase in the number of recipients of the service from 20,827 at the 31 December 1978 to 28,234 at the 31 December 1982. At the same time the average number of home help hours per client per week has fallen from 5.7 in 1979 to 4.8 in 1982.

Meal Services

The elderly are the major users of meal services which are designed to provide cooked meals for people who cannot cook or obtain a meal in any other way and who are nutritionally at risk. Meals-on-wheels cater for those who cannot attend a lunch club but may also be provided in some districts for people who are not house bound, perhaps because lunch clubs have not been developed. Most meals-on-wheels provided are delivered by volunteers and voluntary workers who also help in lunch clubs. At the 30 November 1981 approximately 5,500 meals were being served each week through the meals-on-wheels service to approximately 2,700 people.

Neighbourhood Warden Service

This service which began some time ago in Belfast has been expanding steadily over the past few years through the Eastern Health and Social Services Board area. There are also several schemes in operation in the Northern and Southern Board Areas. A resident of the neighbourhood is appointed as a warden available to old people living within a defined district. A warden can call in other services provided by the Health and Social Services Board when they are needed and may act as a distributor of meals-on-wheels for the neighbourhood. At the 31 December 1981 there were 116 schemes covering 4,000 dwellings. In these dwellings there were 3,232 people living alone and 1,316 living with others.

Aids to Daily Living

A variety of aids designed to help with bathing, using the toilet, dressing, eating, walking and pursuing hobbies are available on loan from Boards. Help may also be obtained to adapt houses to make them more suitable for elderly, disabled occupiers, for example, by building ramps to ease the use of wheelchairs or by fitting grab rails within the house. There is no information available on the extent to which these services are provided.

Day Services

The main purpose of day care services is to improve the quality of life of elderly people living at home and thus to prevent or postpone

the need for admission to residential or hospital care. Day care services are designed to cope with medical and social problems which do not require admission to an institution. They also help people discharge from residential or hospital care to resume life in their own homes. Existing day care services do not make adequate provision for the needs of mentally confused elderly people.

The primary function of a day hospital is to undertake medical investigation, treatment and rehabilitation. At present there are approximately 170 geriatric day hospital places in Northern Ireland.

Day centres are defined as centres which have a full time organiser and where professional staff are employed. They are open all day for 5 or more days each week, providing a variety of activities for members and facilities for meals, bathing, hairdressing, chiropody etc. At 31 December 1981 there were 35 centres in the Province providing 1,749 places with an average daily attendance of 1,219 people of varying ages. Most centres cater for a range of client groups and statistics on daily use by the elderly are not, therefore, available. However about 2,800 elderly people attended day centres during the year ended 31 December 1981.

There are old people's clubs, lunch clubs and social centres throughout Northern Ireland. Old people's clubs are organised by and for old people and are run by voluntary committees. Lunch clubs provide meals in a social setting for mobile, elderly people in need. Social centres concentrate on providing social and craft activities for the handicapped and elderly and these are organised by professional staff.

At 31 December these various facilities provided about 20,000 day places for a number of client groups, the major group being the elderly.

Recent Policy Developments

In October 1979 the Department of Health and Social Services appointed a committee to review the Health and Personal Social Services provided for elderly people in Northern Ireland. The remit was wide-ranging and the committee sought written evidence from a large number of interested voluntary organisations and professional groups, some of which also gave oral evidence.

In drawing together their priorities and recommendations the committee identified the following as the major guidelines to be followed in planning the future development of services for elderly people:-

"a. Elderly people should be given every possible help to maintain their independance at home with support from families, friends and the community.

b. A high priority should be given to ensuring that adequate help from the statutory community services is given to elderly people who most need it to enable them to remain in their own homes.

c. Close attention should be given to assessment procedures in residential homes and hospitals with a view to ensuring that rehabilitative work is put in hand as soon as possible after

the arrival of the elderly person.

d. Given the present economic climate the development of services must begin by ensuring that effective use is made of existing facilities and where possible by reallocation of resources before additional money is sought."

The report distinguished the following as the top priorities in particular fields of service:-

"a. The development of an adequate and comprehensive psychiatric service for elderly people, including domiciliary and day-care services, the provision of more special purpose-built residential homes and more psychogeriatric hospital accommodation;

b. The progressive development of community services, residential provision being regarded as a priority only in those areas where a serious gap exists in the present range of services." (28)

In 1983 the Department of Health and Social Services published its regional plan for Health and Personal Social Services. The plan noted that because additional money was likely to be limited it would not be possible to develop services on a broad front. Five top priority areas were identified and among these were services for the elderly. The overall aim of services for the elderly was described as "to keep pace with the pressures caused by the increasing number of elderly people in Northern Ireland, in particular to provide an adequate psychiatric service for old people and to develop further the

community services." Within this overall aim the priorities up to the year 1988 are described as:-

- The implementation of a phased development programme for psycho-geriatric and geriatric accommodation including new psycho-geriatric units at Holywell and Purdysburn Hospitals and new geriatric units and day hospitals in the Southern and Western areas to replace out-of-date units at Tower Hill and Erne Hospitals respectively;

- the setting up of a Hospital Advisory Service concerned primarily with the long-term care of patients in psychiatric hospitals, geriatric hospitals and hospitals for the mentally handicapped;

- in Belfast, the provision of 2 new residential homes - Thorndale Home for the Confused Elderly and Woodstock Road Old People's Home - and 3 new day centres - Sandy Row, Whiterock and New Lodge;

- limited expansion of community services, including community psychiatric nursing services and paramedical services;

- better direction of primary care and the domiciliary care services towards people with the greatest needs;

- continued support for informal caring networks, such as relatives, neighbours and friends, for old people and for voluntary bodies providing services for the elderly." (29)

This is the latest policy statement on services for the elderly in Northern Ireland.

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CHAPTER 5

THE DEVELOPMENT AND CONDUCT OF THE CASE STUDIES

In the last 2 chapters current Government policies for health and personal social services for elderly people have been examined. These chapters have reviewed the present state of these services and examined the organisational structures by which they are delivered. Also examined have been a number of inter - and intra - organisational aspects of these arrangements which were designed to facilitate the implementation of these policies. However, reference was made earlier to the suggestion that the development of domiciliary services has relied largely on professional judgements and has been influenced by demands from pressure groups rather than on the statutory powers of the Secretary of State. Another related issue is the suggestion that the use of scarce residential services is subject to the way in which these resources are allocated.

It is these issues which led to the decision to conduct 2 case studies. The first of these studies is on the home help service as representative of the domiciliary services designed to facilitate community care of elderly people and the second is on 2 aspects of residential care, current residents and admissions to residential homes.

The Home Help Service

As we have seen in previous chapters the aim of Government policy for elderly people has been, and still is, to keep them active and independent in their own homes (1). The role of the domiciliary services is obviously crucial in working towards this aim.

Social care for the elderly in their own homes takes a variety of forms. The most essential are the home help service providing basic cleaning but in many cases also help with shopping, cooking, laundry and personal care, developing increasingly into a more comprehensive home care service; and meals-on-wheels - the provision of a ready cooked or ready-to-cook meal in the elderly person's home. Many other forms of care can provide further support. Some of these have developed as supplements to the home help service. There are, for example, various forms of "good neighbour" schemes carrying out brief but regular tasks such as getting an elderly person up in the morning, lighting coal fires, popping in to make a cup of tea or just making sure the old person is all right. At the other extreme are intensive care schemes involving much more flexible and concentrated help than the 2-4 hours per week of a home help's time generally available. Some areas also provide day sitters and night sitters, heavy cleaning and gardening squads, surveillance and visiting schemes including street wardens and peripatetic wardens, alarm systems, laundry services for the incontinent and others.

Goldberg and Connelly (2) have suggested that studies of the home help service reveal a considerable lack of clarity about objectives.

Although the home help service was originally instituted as a domestic help service, the multiple needs of very frail elderly people who form an increasing proportion of the home help clientele are raising new questions about aims and functions. Is the primary aim to provide a general domestic cleaning service for those who can no longer carry out those chores, or should it develop into an intensive personal care service taking on a multitude of tasks for very frail and dependent elderly people, especially those who live alone?

In 1979 a study carried out by Bradford Social Services Department into the ways in which the home help service was being used concluded by spelling out recommended aims and priorities (3). This was thought to be essential because, as in other studies, the researchers found that clients living in different parts of the district exhibiting apparently similar needs and circumstances received a very different allocation of hours. The broad general aim was to assist old people to live in the community as long as possible, thereby delaying the need for entry into old people's homes and geriatric hospitals. Three priority aims were recommended:

1. that personal care should take priority over cleaning although certain guidelines were established about cleaning tasks;

2. that consistency of practice should be established across the whole catchment area;

3. that generally persons under 75 years of age should only be provided with a service where there was also a handicapping

condition which reduced their ability to carry out personal care and essential household care tasks.

In a later study (4) this researcher also found that there was little correlation between the number of hours allocated and the needs and circumstances of individuals. It was suggested that the service was not being properly targeted and that a more discriminatory approach should be used.

Although the majority of the evidence, both nationally and locally, suggests that domiciliary care by and large goes to those most in need of it - that is to say to the frailest and most disabled and to the very elderly, (5, 6) individual cases raise considerable problems in defining and assessing the nature and intensity of need. A number of studies on the home help service have been prompted by the suspected discrepancies between the levels of service in various districts of a local authority. Results have been startling. One study (7) revealed that clients in one area might receive over twice as many hours of home help as clients in an adjacent area even though their social characteristics, disabilities and living arrangements seemed quite comparable. Another study (8) points to the more intangible factors that home help organisers take into account: for instance new clients' customary standards of cleanliness, the state and quality of furniture and the need not to undermine the motivation for self-help.

Goldberg and Connelly (9) suggest that more general factors may also play a part in the discrepancies found in resource allocation eg in localities where the local Government re-organisation of 1974 has

combined an urban area with high levels of service provision and an adjacent rural area with different philosophies and levels of service. Another contributory factor could be the existence of deliberate but different rationing devices, so that in one area the home help organiser might prefer to give all those above a minimum level of disability, a standard 2 hours of the service per week whereas in another district the preferred policy might be to provide home help on a more flexible intensive basis to a smaller number of cases. Whatever the reason the mismatch between a current need and actual service delivery seemed clear to researchers who interviewed users directly. They were surprised at the number in each area who seemed to be in little current need of the service received. For example, in a study in Wales almost one-third of a random sample of home help clients interviewed were capable of leaving their homes unaided (10). In the study by this researcher referred to earlier (11) almost three-quarters (73%) of the recipients of the home help service were described as having none or only slight behavioural difficulties as measured on a dependency rating scale.

It is clear from the foregoing that the allocation of the home help service to clients and the number of hours per week allocation do not follow any evident rational pattern and would appear to be determined at local level on the basis of locally developed criteria. It was for these reasons that it was considered necessary to investigate the decision-making process concerning the application for the allocation of the home help service. In addition it was also thought necessary, as a fore-runner to this aspect of the study, to investigate the characteristics of elderly people who make up over 90% of the

recipients of the service. This was considered necessary because of the absence of any earlier studies of the home help service in Northern Ireland.

The case study of the home help service had 2 aims.

a. to investigate the characteristics of elderly recipients of the service and the type of service provided; and

b. to examine the decision-making processes concerning the application for and allocation of the service.

The investigation of the recipients of the service was designed to:

i. describe the elderly clientele of the home help service;

ii. compare clients with those receiving other services;

iii. compare services between districts; and

iv. compare levels of service with some measure of need.

The examination of the decision-making process was designed:

i. to examine the stages in decision-making;

ii. to identify decision-makers;

iii. to compare variations in decision-making; and

iv. to analyse variations in procedures and policies in the provision of the service.

It was intended to conduct this part of the exercise in 2 districts selected for part (a) of the case study and to interview the senior officer responsible for the administration of the service in 4 offices - 3 in one district and one in another. Subsequently, for reasons which will be discussed below, it was not possible to obtain the co-operation of the staff in one of the districts and therefore it was not possible to complete the inter-district comparative element referred to above.

Residential Care

The Department of Health and Social Security has issued guidance (12, 13) on health and personal social services institutional provisions which suggests different types of accommodation are appropriate for different categories of old people. Those whose physical health necessitates continuous medical or nursing care should be cared for in

geriatric wards, those suffering a degree of mental illness or infirmity which warrants medical or nursing care in psychiatric wards, and the remainder, whose condition does not warrant specialised health care, but who are unable to live in the community, should be cared for in residential homes. While such statements are of little practical help in determining appropriate placement a number of studies (14, 15) of the elderly in residential care suggest that it is possible, on the basis of a measure of the individual's level of physical and mental functioning, to determine appropriate institutional placement. Whilst some elderly people are judged to be appropriately placed in non-specialist residential homes, others are considered by virtue of severe physical and/or mental illness or impairment, to require more specialist care. A third group is judged not to require institutional care at all, and it is suggested that these people could be discharged to their own homes, the homes of relatives or sheltered housing. Similar judgements are also made in a number of studies (16, 17) of elderly people in hospital, suggesting that some patients are misplaced and would be more appropriately cared for in different types of hospital or in residential homes or in the community.

Recent work (18) by this researcher revealed that, out of 1,121 elderly people occupying beds in a hospital or residential home on a given date in 1980, 207 (19%) people were considered to be inappropriately placed. Among the 28 found to be misplaced in residential homes it was considered that 10 would have been better placed in a geriatric ward; 9 required placement in a psychiatric hospital and 4 could have returned home. Out of 50 people misplaced in geriatric wards, 18 were considered suitable for residential care,

11 for psychiatric hospital and 9 could have returned home. Acute wards contained the highest number of "misplaced" people and, among the 73 people identified, 45 (62%) were considered to require placement in a geriatric ward.

The majority of residential homes cater for a wide variety of residents in terms of their physical and mental capacities and many of these people suffer a degree of illness or infirmity which is beyond the scope of residential care as originally envisaged. Current policy maintains that residential homes should not be expected to cater for old people who are ill or very infirm, or for those who are capable of leading an independent life in the community, although the criteria for placement contained in policy statements are insufficiently explicit to serve as a guide to determine which individuals should be cared for in other settings.

While the researcher had available to him the information from a recent study in Northern Ireland of the characteristics and features of residents in homes in a Health and Social Service District, an earlier study (19) suggested that there were marked differences in the characteristics of residents in homes in the eastern part of the Province compared with those in the western area. In order to validate this statement and provide an accurate and current picture of the residents in homes in the study area a census was required.

Despite undoubtedly high and increasing levels of physical dependence and behavioural problems associated with mental infirmity among residents of local authority residential homes (20, 21) various

studies have found large numbers of elderly in the community who are equally infirm and who remain in their own homes unknown to health and social services (22). Thus it is apparent that a degree of mental and physical infirmity is not a sufficient condition for admission to residential care although it may increasingly become a necessary one.

In a study of 322 applications for Part III accommodation Neill examined the characteristics of the applicants (23). She found that a claim of "risk" for the elderly person was frequently present in applications particularly where people lived alone. It was not always clear how this assessment was arrived at as most of the cases were visited frequently by relatives and received domiciliary services. The other prominent reason underlying applications was stress on supporters with interacting problems of applicants and care-givers being a feature of two-thirds of applications, and the overriding factor in one-fifth of them. There appeared to be a marked absence of service specifically to relieve others.

In another study (24) Avon County Council investigated the background to 231 admissions to homes for the elderly. This study also revealed the importance of "risk" (48% of admissions) and "stress on supporters" (30% of admissions). The conclusion drawn was that "any system of admissions has to make a trade off (perhaps implicitly), between admitting persons living alone who are "at risk" and admitting persons less "at risk" but causing stress on others". In Avon it was found that many of the admissions primarily produced by "risk" were emergencies which by-passed the allocation meeting. While these studies have dealt with the idea of "need" as the determinant of

admission other research (25) has looked at the processes by which particular elderly people were allocated particular vacancies. This research is rooted in the observation that many social work agencies have rejected a rigid points system for selecting people for residential accommodation "and now work with a flexible approach in which "need" is the main criteria", so that the working procedures and organisational context of those making decisions become important for deciding who becomes resident. Two recent studies exemplify different approaches to policy formulation on admission to homes.

Ovenstone and Dean (26) studied 272 residents admitted consecutively to local authority residential care in Nottingham. They found that 56% of the cases examined were appropriately placed being "frail old people no longer capable of living an independent existence in the community, and whose level of functioning was commensurate with a residential setting". On the basis of medical, psychiatric and behavioural findings a second group (32%) were classified as "inappropriately placed" and needing hospital care. A third group (12%) "could have remained in the community had there been adequate social assessment and support". Such conclusions begged the question of what are the purposes and admission policies of residential homes and these authors go on to question the DHSS guidance that homes should offer "the type of care which might be given by competent and caring relatives." They suggest that old people's homes "have become surrogate psychogeriatric/geriatric hospitals" and should be staffed accordingly with some residential staff having nursing care training.

By way of contrast a study by Masterston and his colleagues (27)

arrives at a completely different conclusion based on an examination of the population of 11 local authority homes in Glasgow, in which they "found no evidence of increasing numbers of dependent residents being cared for within local authority homes for the elderly". This is related to "a policy of the selective panels for local authority residential care which rejects severely disabled old people ... a realistic and desirable acknowledgement of the resources of their staff and buildings are finite".

The lack of clarity over policies as to who is suitable for placement in a residential home and the general lack of agreement surrounding the concept of "Part III Fitness" are aspects which need clarification. It is also important to acknowledge an examination of the process leading to residential home allocations and admissions is as important to an understanding of how and why elderly people get placed in homes as a study of the characteristics of elderly people so placed.

Thus the need to examine the degree of "misplacement" among current residents and the processes involved in the allocation of places lead to the development of a case study which had 2 aims. The aims of this case study were:-

a. an examination of the characteristics and presenting feature of residents in all old people's homes throughout the Board's area to ascertain if there was any significant number of residents "misplaced"; and

b. an examination of those elderly people admitted to residential care and of the decision-making process concerning admissions.

The Study Area

The area in which the studies were conducted is the Western Health and Social Services Board. The choice of area was fortuitous rather than planned. Initially it had been planned to conduct the studies in the East Belfast and Castlereagh district of the Eastern Board in which some earlier work recorded in the author's M.Sc. dissertation had been undertaken. However certain problems in residential care in that district made that approach very difficult and an alternative was being sought when the researcher was approached by an Assistant Director of Social Services and asked to assist the Special Interest Group for the Elderly in the Western Board's area with the development of a more comprehensive application form for residential care. It was from these discussions that access to the Western Board was negotiated.

The Western Board is the smallest of the 4 Boards in Northern Ireland serving a quarter of a million people, some 16.4% of the population (1981 census) and spending this year, 1984/85, around 15% of the revenue resources available to Boards. The geographical area for which the Board is responsible comprises about 1,800 sq miles, stretching more than 90 miles from north to south. The area is largely rural in nature apart from the city of Londonderry, the nearby towns of Limavady and Strabane and the county towns of Omagh and Enniskillen. The Board's service are administered through 3 Units of Management:-

a. Londonderry, Limavady and Strabane,

b. Omagh and

c. Fermanagh.

In 1981 the birth rate was 21.6 per 1,000 population which is markedly higher than that for Northern Ireland as a whole. At the same time, the area has the lowest percentage of the population aged over 65, 9.9% compared to the regional level of 11.5%

The area has suffered long from the problems of high unemployment, leading to a high level of dependence on social security benefits, and relatively poor housing. While it is not possible to determine an unemployment rate for the area as a whole, it has suffered from the recession to produce crippling levels of unemployment in some areas. The 1981 census identified 26.4 of economically active males and 15.3% of females as unemployed. The most recent unemployment figures reveal an unemployment level of 28.5% (36.7% for males) in Londonderry, 26.2% (30.4% for males) in Enniskillen, and 39.1% (50.2% for males) in Strabane - all these travel to work areas being contained within the Board area. When set against the Northern Ireland level of 21% (26.8% for males) the particular plight of the area is clear. In 1979 the house condition survey revealed that almost 20% of dwellings in the area were unfit, the bulk within single dwellings rather than areas earmarked for clearance and redevelopment. The average household size in the area is estimated at 3.65, based on the 1981 census, higher than the rest of Northern Ireland. There is

little information available on the average level of income in the area but a survey of families of dependent children in Northern Ireland conducted in 1979 suggested that, of these families in the western area, 46% had a weekly income under £ 70 per week and over 20% relied on social security as the main source of income.

In 1983/84 the Western Board spent some £70m on health and social services, capital excluded. The expenditure pattern of the Board, in broad categories, in 1981/82 was as follows:-

Hospital specialist and related services - 69.0%

Community Health Services - 7.0%

Personal Social Services - 18.0%

HQ and district administration - 6.0%

In an alterative analysis of the pattern of expenditure, Board figures for the distribution of revenue expenditure by programme of care in 1980/81 were:-

General Hospital Services -38%

Community Health Services - 7%

Mental Health Services -21%

Care of the Elderly - 20%

Mentally Handicapped - 7%

Physical Handicapped - 3%

Child Care - 4%

Consultation

Following the negotiation of access to the Western Board with the Assistant Director of Social Services there followed a lengthy and involved series of consultations and meetings with a large number and variety of staff within the board. In total 32 meetings were held with individuals or groups of staff during the period 5 February to 14 October 1982 (see Annexe A). The need for such extensive range of consultations arose from the multi-tiered administrative arrangements within the social services department. Following an initial approach to the Director of Social Services the next meeting was held with his second line officers. The Board had, in 1981, appointed a Special Interest Group for the elderly which was representative of all 3 districts, fieldwork and residential and day care management staff. It was thought by the Director of Social Services that this group would be a useful liaison group for the case studies and it was agreed that the researcher would attend the regular meetings of this group to negotiate access to districts, to iron out any problems arising and give reports on progress.

Trade Unions

During the period February 1982 to October 1982 the researcher had negotiated the layers of administration within the Board and successfully conducted a census of residents in homes for the elderly in June 1982. The census of elderly recipients for the home help service was planned for 31 october 1982 in 2 districts of the board. One district was geographically small and had one office base; the other was large and had 3 main sub-offices. Fieldwork staff in all offices had been involved in discussions about the case study, some had participated in a pilot study of the questionnaire to be used and all were committed, with local management to the exercise. By the last week in October all staff had been fully briefed and questionnaires had been delivered to all offices. Local management had made arrangements for staff to have time off from their normal duties to participate in the exercise and some staff had completed the questionnaires. Early in 1982 the Ancillary and General Joint Staff Council had successful negotiated improved terms and conditions for all home helps in Northern Ireland which was placing additional administrative requirements on Boards. The bulk of this work fell to the social work assistants who in Northern Ireland administer the service and their union, the Northern Ireland Public Services Alliance were monitoring the situation. As part of this exercise the union had called a meeting for 26 October 1982 and during this meeting a representative from the Western Board mentioned the census which was being conducted in that Board's area.

Following this meeting on 26 October the researcher received a phone

call from the Assistant Secretary of the Union saying that the Union was instructing its members not to co-operate with the exercise. A letter to the Assistant Secretary of the Union, an offer to meet him and his members, an approach to the Assistant Secretary of the researcher's own staff association (incidentally part of the same union) and informal approaches from management of the Board failed to persuade the union to lift the embargo. Correspondence with the union is attached as Annexe B. The union's embargo, however, had no effect in one sub-office in the large district. Only one member of staff among 5 was in membership of the union. The office manager and the other social work assistants were not in sympathy with the views of the union and all social work assistants (including the union member) agreed to honour their commitment and complete the questionnaires. Therefore while the comparative element of the case study was lost a complete and total picture of the elderly receiving the home help service in one sub-office area was obtained.

Methods

The Home Help Service

The first aim of this case study was

- to investigate the characteristics of elderly recipients of the service and the type of service provided.

For the reasons outlined earlier it was not possible to obtain 2 sets of information from different districts and this aim has been

achieved by an analysis of all the elderly recipients of the service in one sub-district area.

A pilot study was carried out to test the questionnaires. Draft questionnaires covering the topics for inclusion in the study were tested in 3 sub-offices of one of the districts proposed for the study. In each of these offices one social work assistant completed 10 questionnaires. From this study the amount of time required to complete the forms was learned. As staff became more familiar with the forms they were able to complete them more quickly. This study also provided some feedback on the relevance of the content of the forms and the layout, and demonstrated the need for slight modifications which were incorporated in the final version.

The questionnaires used, HH1 and HH2, took approximately 10 minutes to complete in the pilot exercise. These are attached as Annexe C and D respectively. Topics covered were:-

a. Referral details

b. Household circumstances

c. Tasks performed by the home help.

d. Time allocation

e. Other help

f. Accommodation

g. Household facilities

h. Behavioural characteristics

i. General

In the sub-district participating in the study each social work assistant was asked to complete a questionnaire (HH1) in respect of each household containing an elderly person to which the home help service was provided and a questionnaire (HH2) in respect of each elderly person in the households identified. Before completing the questionnaires all the social work assistants in the sub-office were briefed on how to fill in the forms and notes of guidance provided for sections 12 to 21 on the form HH2 (see Annexe E). The census date was set for 31 October 1982 and the time limit given for completion of the questionnaires was the end of November although this was not met by some staff and all forms were returned by mid-December.

After the return of the questionnaires to the office they were coded and checked for accuracy of completion. The forms were then used as punching documents for keying onto computer tape. The data was then analysed by staff from the Department's Management Service Division to the researcher's specification using the Scientific Information Retrieval (SIR) package on an ICL 2900 mainframe computer.

It is acknowledged that bias can arise from a variety of sources. It can be introduced from incorrect sampling frames, non-completion, questionnaire design, wrong information from social work assistants,

coding or analysing errors.

It is difficult to determine the level of bias in such a survey. The population studied was, however, relatively small, did not involve sampling and checks with the management staff suggested that the level of non completion was negligible and should have reduced bias. What could have caused bias was probably linked to the social work assistants' interpretation of some of the questions especially on the behavioural rating scale and limited knowledge of some of the cases. Coding errors were kept to a minimum by using a pre-coded form which was thoroughly checked before being placed on the computer and by the use of computerised range and logic checks.

The second aim of the case study was:-

To examine the decision-making process concerning the application for and allocation of these services.

As mentioned earlier it was not possible to conduct this part of the study in 2 districts. Therefore the focussed interview using the schedule attached at Annexe F was used with 3 management staff in charge of the sub-offices in one district. While the structured interview approach ensured that the same questions were asked of each of the respondents all of whom received a copy of the schedule before interview the researcher could not be sure that the "right" questions were being asked. The approach adopted was also limited in that the questions were addressed to one level of staff - management. Given more time the exercise could have been extended to include a

prospective study of new referrals for the service. This could have included an examination of referral decisions, the decisions of senior social workers to allocate referrals and an examination of the influences on the decisions of field work staff in the allocation of the service.

Residential Care

The first aim of this case study was

- an examination of the characteristics and presenting features of residents in all old people's homes throughout the Boards's area to ascertain if there was a significant number of residents "misplaced".

This was achieved by the conduct of a census on 30 June 1982 of all residents in old people's homes throughout the 3 districts of the Board. The homes are located in the 3 districts as follows:-

Londonderry, Limavady and Strabane - 8 homes

Omagh - 2 homes

Fermanagh - 3 homes.

The largest of these homes has 61 places and the smallest 30 places. There is a mixture of converted and newer purpose-built homes, the latter mostly providing 30 places each. There is one specialist home for the elderly mentally infirm in the Londonderry, Limavady and

Strabane District. The overall level of residential provision is 19.5 per 1,000 old people which is below the norm recommended by the Department of Health and Social Services.

The questionnaire RA1, see Annexe G, sought information about age, gender, marital status, living arrangements prior to placement, dependency levels, appropriateness of placement, alternative placements and other general information. A pilot study was not conducted to test the questionnaire as it had been used by the researcher for his earlier study in East Belfast and Castlereagh and no major shortcomings had been identified. However, 2 additional questions had been added to include reference to the old person's perception of the need for an alternative placement where staff thought one was necessary.

In the homes participating in the study the head of each home or deputy head was asked to complete a questionnaire in respect of each person resident in the home at 9.00 pm on 30 June 1982. Before completing the forms a briefing session was held separately in each of the 3 districts and notes of guidance on the completion of Sections 10 to 19 provided. These notes are contained in Annexe E. The time limit set for the completion of the questionnaire was 14 July and this was met by all staff.

After the return of the questionnaires to the office they were coded and checked for accuracy of completion. The forms were then used as punching documents for keying onto computer tape. The data was analysed by staff from the Department's Management Services Division to the researcher's requirements using the same equipment used for the

analysis of the home help service data - the Scientific Information Retrieval (SIR) package on an ICL 2,900 main frame computer.

The earlier consideration of bias in relation to the questionnaires used in the home help study is appropriate here especially in relation to the assessment of the dependency of residents. However, the earlier work by this researcher and the work of Wilkin and Jolley (28) who carried out statistical tests on its reliability and validity should alleviate any concerns on this score.

The second aim of the case study was

- an examination of those elderly people admitted to residential care and of the decision-making process concerning admissions.

The examination of those elderly people admitted to residential care and of the decision-making process concerning admissions had a number of objectives. These were:-

i. to determine the main reason for the admission of elderly people to residential care;

ii. to examine the stages in decision-making; and

iii. to analyse procedures and policies concerning the allocation of places.

To achieve objectives the researcher examined retrospectively the case

papers and associated reports for each old person admitted to residential care in each of the 3 districts in the Board's area during the period 1 July 1982 to 31 December 1982.

This approach relied on an analysis of the application forms completed by or on behalf of the applicants for residential care and the social report which accompanied these forms. There was no opportunity to check the reliability or validity of the information and in many cases the social reports were very concise. A better approach, if the time had been available, would have been to conduct a prospective study which examined each admission when or shortly after it occurred and which involved an interview with the principal actors in the situation - elderly person, social worker, relatives, if appropriate, and residential care manager. However despite the limitations the information collected does give some useful insight into the characteristics of those currently being admitted to residential care in this Board's area and the main reasons for these admissions.

The remaining objectives have been achieved by the researcher interviewing the manager of residential care in each of the 3 districts using the focussed interview schedule attached as Annexe H and by attending 2 meeting of an allocation panel in one district. The consideration of the use of a structured interview schedule in relation to the home help service case study is relevant here. The interviews were conducted with only one person in each district - the manager of residential care. The questions were devised by the researcher on the basis of his knowledge of arrangements in other locations and not with the benefit of a detailed knowledge of the

systems operating within that Board. One can only speculate that the "right" questions were used. Interviewees were asked if they wished to add anything to the interview schedule or supply additional information. None elected to do so. Therefore, one may assume that the questions asked were appropriate and exhaustive.

Again despite the limitations of the information collected it will be possible to provide some insight into the policies, procedures and decision-making processes at work in the allocation of residential home places in the Western Board's area.

The results of the case studies are presented in the next 2 Chapters.

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CHAPTER 6

CASE STUDY 1 - THE HOME HELP SERVICE

In this chapter the results of the case study on the home help service are presented. The analysis is presented in 2 sections:-

i. recipients of the service;

ii. the decision-making process.

RECIPIENTS OF THE SERVICE

In total 267 households containing elderly people were identified as being in receipt of the home help service. In 213 households, 80%, there was one elderly person; in 53 households, 20%, there were 2 elderly persons and in one household there were 3 elderly persons.

Household Characteristics.

Location

Out of the 267 households almost two-thirds were described as being in the town or in the suburbs and just over 30 being remote in the country. There is no measure readily available against which one can judge whether the spread of households of home help recipients is similar to the general population or whether particular groups of recipients are less likely to receive a service. See Table 1.

Table 1. Location of Accommodation

Location of Accommodation	No	%
Remote in Country	82	31
In Village	13	5
In Suburbs	93	35
In Town	79	30
Total	267	100

Type

Table 2 shows the type of accommodation occupied. The vast majority of recipients, just over 80%, lived in a whole house. Information from a sample of 405 households, where the head of the household is 65 years of age or over, from the Continuous Social Monitor (Northern Ireland's equivalent to the General Household Survey) suggests that the pattern for the total elderly population for Northern Ireland may be different. Among the Continuous Social Monitor sample 37% lived in a whole house and 12% in a flat or maisonette.

Table 2. Type of Accommodation

Type of Accommodation	No	%
Whole House	215	81
Flat/Maisonette	4	2
Bedsitter	0	0
Room in Flat/House	1	-
Other	47	18

Ownership

Just over three quarters of recipients of the service lived in rented accommodation - 71% in accommodation provided by the Northern Ireland Housing Executive and 4% in accommodation owned by private landlords- 21% of recipients are owner-occupiers. This pattern is quite different from the Continuous Social Monitor sample in which half lived in rented accommodation, 44% from the Northern Ireland Housing Executive and 6% from private landlords - 47% of the continuous Social Monitor sample were owner occupiers. See Table 3.

Table 3. Ownership of Accommodation

Ownership of Accommodation	No	%
Northern Ireland Housing Executive	192	72
Elderly Person	55	21
Elderly Person's family	7	3
Housing Association	2	-
Private Landlord	10	4
Other	1	-

Number of Rooms

Table 4 shows the number of rooms in the accommodation excluding kitchens less than 6ft wide, halls, landings, bathrooms and WCs. Information from the Continuous Social Monitor sample may not be strictly comparable but in that sample there were only 2 elderly people living in accommodation with less than 3 rooms compared to 46 (19%) of the home help service sample and at the other end of the scale just over 1% of the home help service sample and 12% of the Continuous Social Monitor sample occupied households with 7 or more rooms.

Table 4. Number of Rooms in Accommodation

Number of Rooms	No	%
One	3	1
Two	43	16
Three	61	23
Four	84	31
Five	48	18
Six	24	9
Seven	2	-
Eight	1	-
Nine	1	-

Amenities

In Table 5 the proportion of households having the use of 3 basic amenities in both samples is shown. 90% of the recipients of the home help service had a flush toilet (WC) with an entrance inside the building whereas among elderly people in the Continuous Social Monitor sample the proportion was 88%. Among home help recipients 92% had a piped water supply, a proportion which was slightly lower than the 96% of the Continuous Social Monitor sample of elderly people. The proportions in both samples having a fixed bath or shower were very similar.

Table 5. Basic Amenities in Recipients' Homes

Basic Amenity	Home Help Recipients	CSM Sample
	%	%
Exclusive use of:		
Inside WC	90	88
Piped Water Supply	92	96
Fixed Bath or Shower	89	87
Base for %	267	405

Labour Saving Devices

The proportions of households from the home help service sample and the Continuous Social Monitor sample of elderly people having the use of labour saving devices is shown in Table 6. The proportions having a cooker are very similar but there were marked differences in the proportions having the other 3 devices listed. Only 32% of households receiving the home help service had a refrigerator compared to 74% of the Continuous Social Monitor sample. 35% of the home help service households had a washing machine compared to 49% in the Continuous Social Monitor sample and just over half, 52%, of the home help service households had a vacuum cleaner compared to over three-quarters, 78%, of the Continuous Social Monitor sample.

Table 6. Labour Saving Devices in Recipients' Homes

Labour Savings Devices	Home Help Recipients	CSM Sample
	%	%
Cooker	97	99
Refrigerator	32	74
Washing Machine	35	49
Vacuum Cleaner	52	78
Base for %	267	405

Fuel

Among the recipients of the home help service 212 households (91%) had coal fires. The proportion of elderly people in the Continuous Social Monitor sample using coal, smokeless fuel and peat was 95%.

Personal Characteristics.

In the 267 households in the study there were 325 elderly people.

Source of Referral

The major source of referral for this service was from the elderly

people themselves or their relatives. This source exceeded all others with 54% of all referrals. It was followed by referrals from primary health care sources at 22% of cases. The next most significant source was the hospital health care team which accounted for 8% of all referrals. See Table 7.

Table 7. Source of Referral

Source of Referral	No	%
Self Referral or Relatives	177	54
Primary Health Care	72	22
Hospital Health Care Team	26	8
Social Services Staff	4	1
DHSS	7	2
Voluntary Organisation	2	-
Other	19	6
Not Known	18	5
	325	100

Length of Time Known

Table 8 shows the length of time the elderly persons were known to the Social Services Department. Most recipients had been known to the Department for a considerable length of time - 65% had been known for

more than 2 years and 38% for more than 5 years. Only 6% were known to the Department for less than 6 months.

Table 8. Length of Time Known

Length of Time Known	No	%
Less than 6 months	18	6
6-12 months	45	14
1-2 years	52	16
2-5 years	87	27
More than 5 years	122	38
Not Known	1	-
Totals	325	100

Length of Time in Receipt of Home Help Service

The pattern for the length of time that people had been in receipt of the home help service and the length of time they were known to the Department was very similar. Most clients of the service had been receiving assistance for a considerable period of time - 60% had the service for more than 2 years and 32% for more than 5 years. Only 7% had been receiving the service for less than 6 months. See Table 9.

Table 9. Length of Time in receipt of Home Help Service

Length of Time in Receipt of Home Help Service	No	%
Less than 6 months	24	7
6-12 months	47	14
1-2 years	57	17
2-5 years	92	28
More than 5 years	105	32
Not Known	-	-
Totals	325	100

The length of time people had received the service is analysed by their behaviour rating in Table 10.

Table 10. Length of Time in Receipt of Home Help Service by Behaviour Rating

	Behaviour Rating									
Length of Time	0		1-9		10-19		20-29		30-38	
	No	%	No	%	No	%	No	%	No	%
Under 6 months	7	9	12	6	2	6	1	17	2	66
6-12 months	17	21	28	14	2	6	0	-	0	-
1-2 years	12	15	39	19	5	15	1	17	0	-
2-5 years	25	31	56	28	9	27	2	33	0	-
5+ years	20	25	67	33	15	45	2	33	1	34
Totals	81	100	202	100	33	100	6	100	3	100

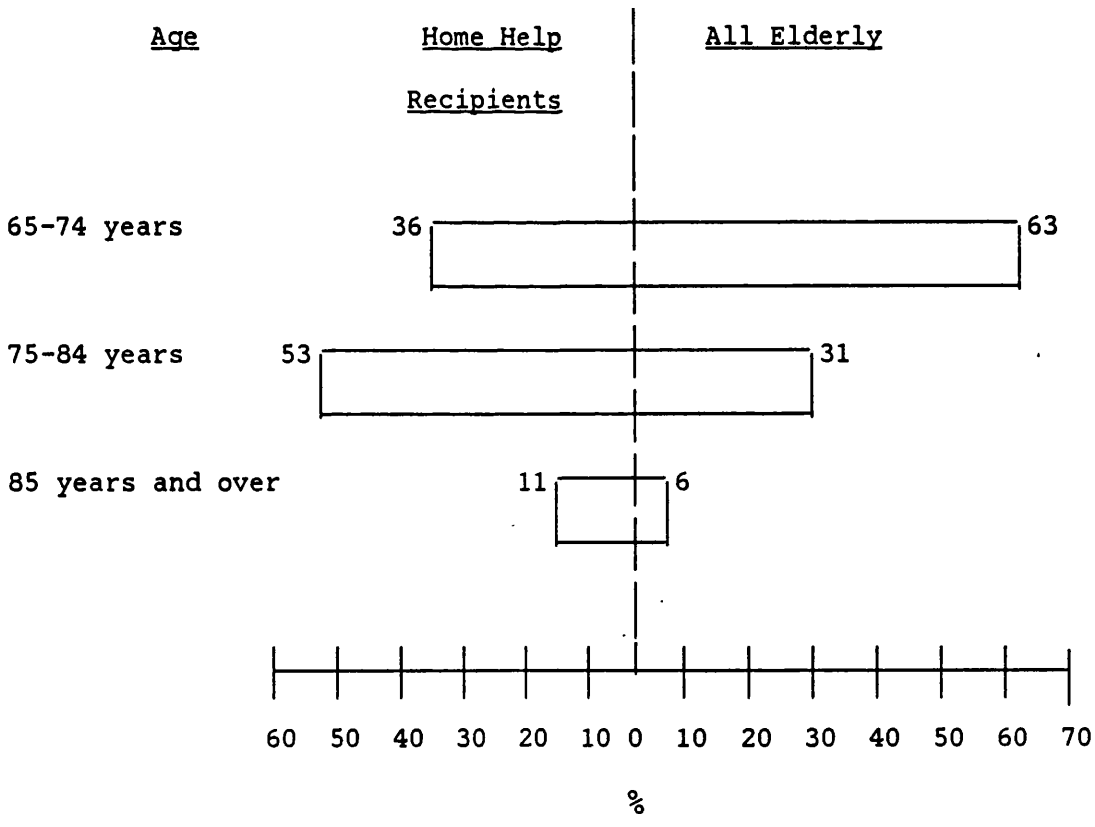
Age

The age of the recipients of the service is shown in Table 11. Among the elderly recipients 36% were in the age range 65 to 74 years, 53% were in the age range 75 to 84 years and 11% were 85 years or over. The age of home help recipients is compared with the total elderly population in the Limavady District Council area for 1981 . Among the total elderly population 63% were in the youngest age range, 65 to 74 years, 31% were in the middle age range, 75 to 84 years and 6% were 85 years or over. It is clear that the 2 older age groups were over-represented among home help recipients. See Figure 1.

Table 11. Age of Recipients

Age	No	%
65-74 years	118	36
75-84 years	172	53
85 years and over	35	11
Total	325	100

Figure 1. Age of Recipients and Total Elderly Population



Another group with whom the elderly people in receipt of the home help service may be compared are those elderly people in residential care. On 30 June 1982 a census of residents in homes for the elderly was conducted. Among the residents in homes in the Londonderry, Limavady and Strabane District, 22% were in the youngest age range, 65 to 74 years, 46% were in the middle age range, 75 to 84 years, and 28% were aged 85 years and over. This comparison is shown in Figure 2 below.

Figure 2. Age of Recipients and Residents of Homes

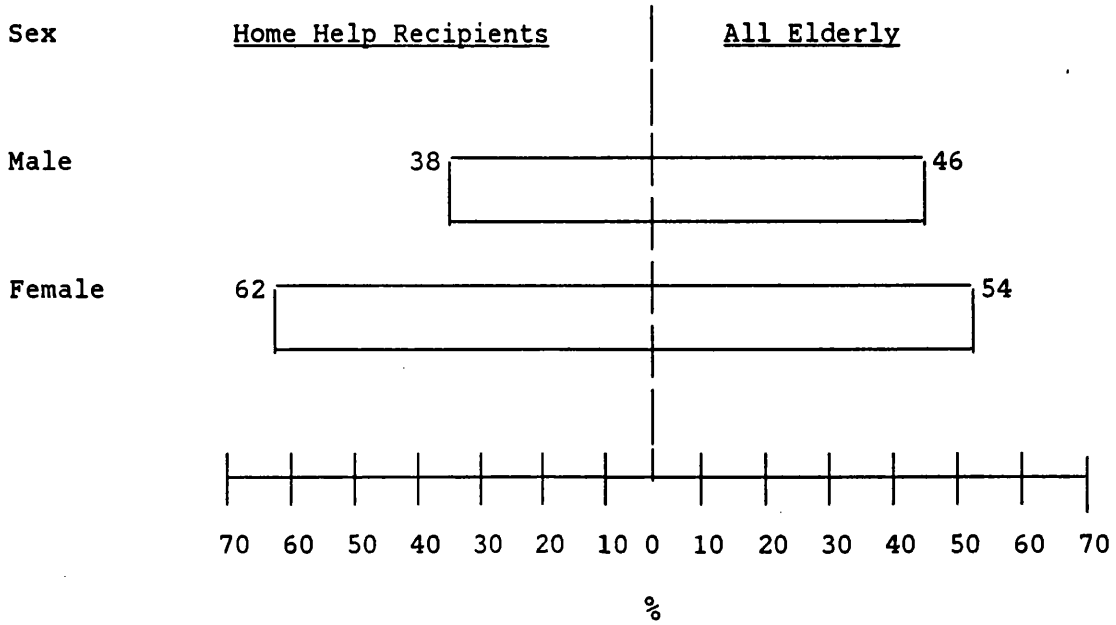
Sex

The sex of elderly people in the households is shown in Table 12. The majority of recipients were female, 62%. The pattern for home help recipients is shown alongside that for the total elderly population in the district in Figure 3. This suggests that females were over-represented among home help recipients and males under-represented.

Table 12. Sex of Recipients

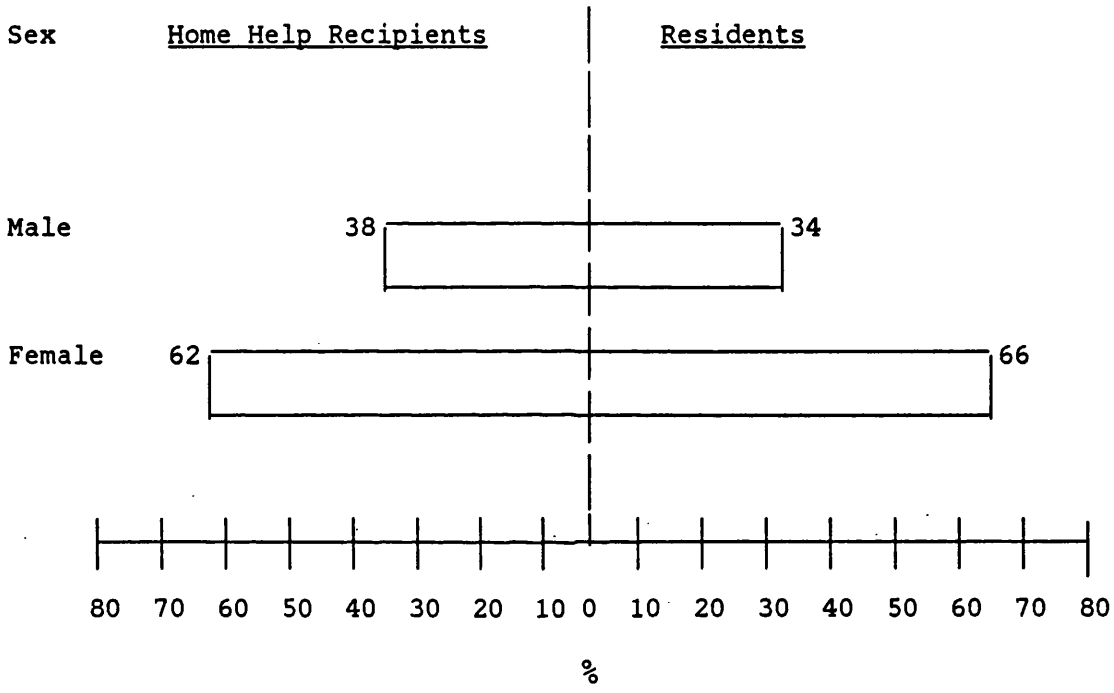
Sex of Recipients	No	%
Male	123	38
Female	202	62

Figure 3. Sex of Recipients and Total Elderly Population



The home help recipients are compared with residents in homes in Figure 4. There was a much closer correspondence between the sex of recipients of the home help service and residents in homes than with the total elderly population

Figure 4. Sex of Recipients and Residents of Homes



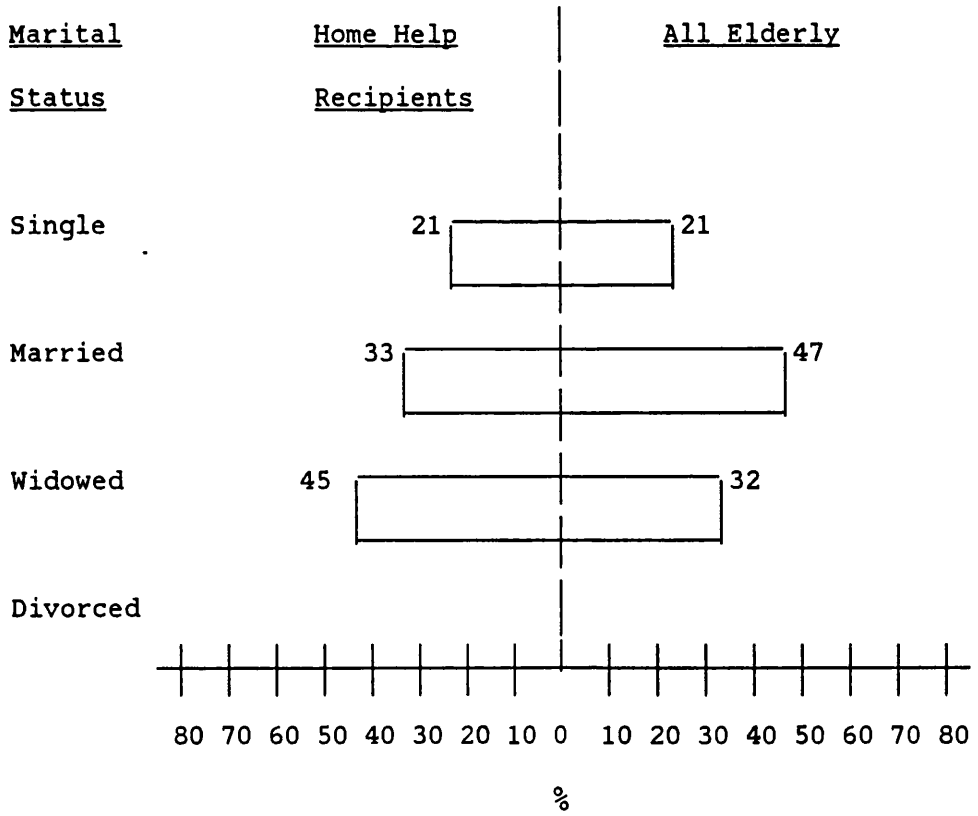
Marital Status

The marital status of the home help recipients is shown in Table 13. 21% of the elderly recipients were single, 33% married and 45% widowed. They are compared with the total elderly population in Figure 5 which shows that a similar proportion were single but a larger proportion (47%) of the total population was married and a smaller proportion (32%) widowed.

Table 13. Marital Status

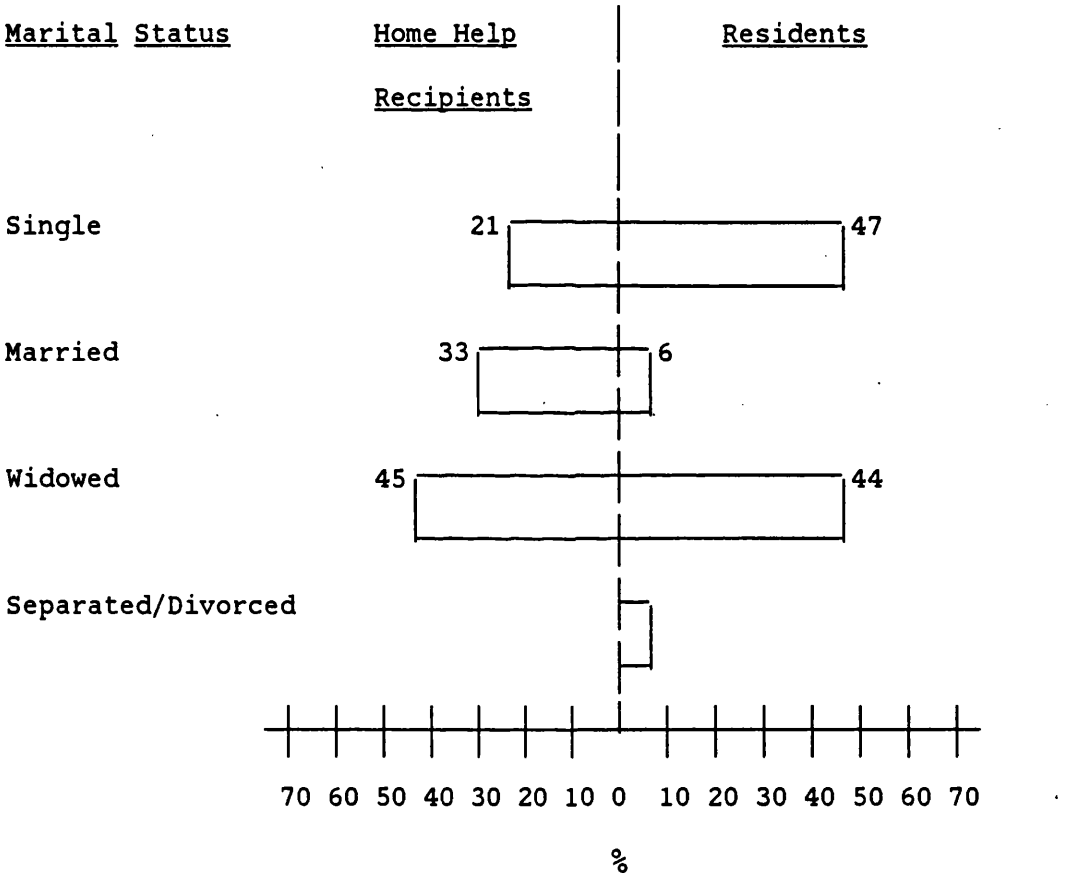
Marital Status	No	%
Single	69	21
Married	108	33
Widowed	145	45
Separated/Divorced	2	-
Not Known	1	-

Figure 5. Marital Status of Home Help Recipients and Total Elderly Population



The marital status of recipients of the service can be compared further with the residents of homes. Among the elderly in old people's homes, 47% were single, 6% married and 44% widowed. See Figure 6.

Figure 6. Marital Status of Home Help Recipients and Residents of Homes



Living Arrangements

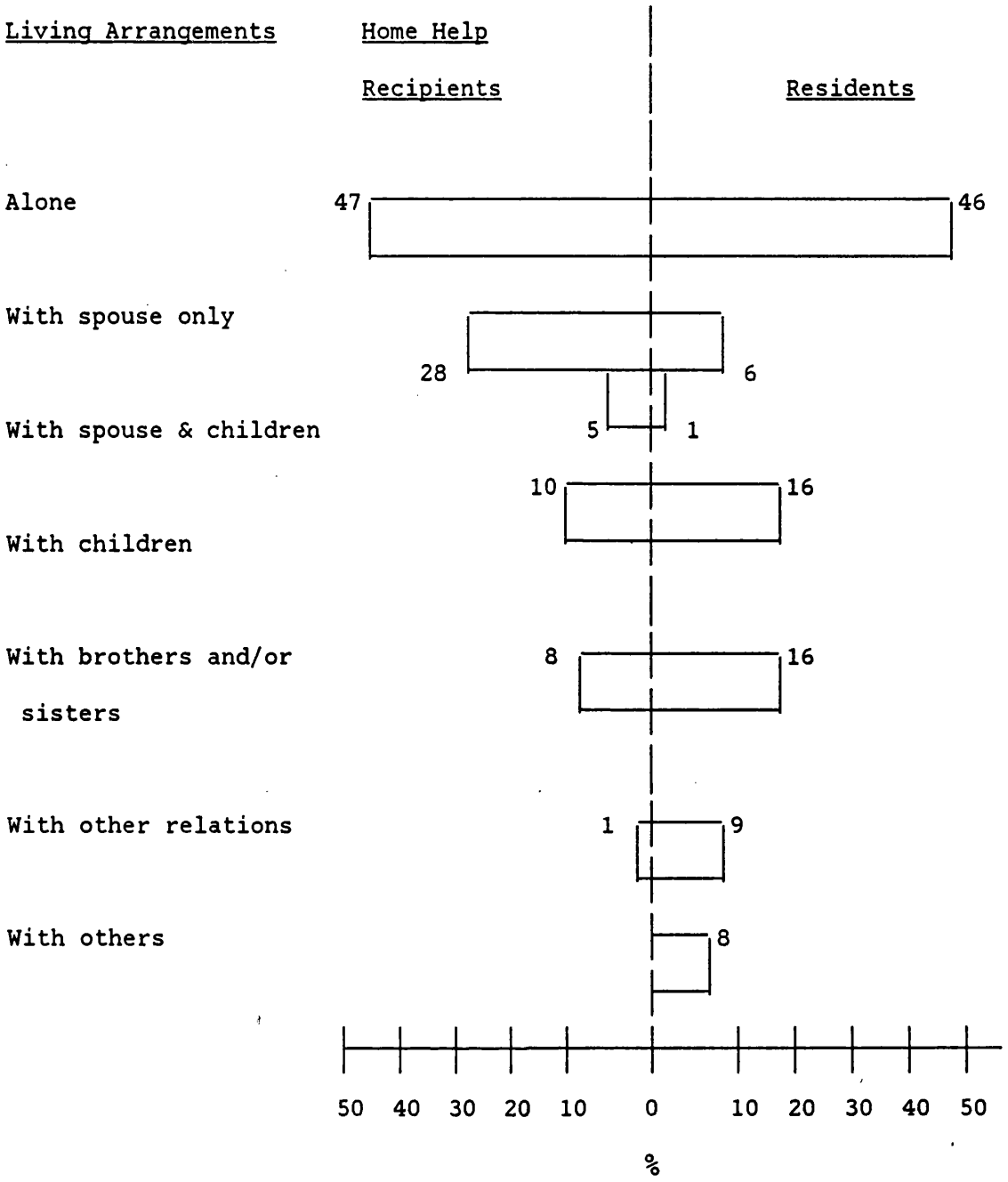
The living arrangements of the home help recipients are shown in Table 14. Almost half, 47%, lived alone and a further 28% lived with a spouse who was also likely to be elderly.

Table 14. Living Arrangements

Living Arrangements	No	%
Alone	153	47
With Spouse only	90	28
With Spouse and Children	17	5
With Children	33	10
With Brothers and/or Sisters	27	8
With Other Relations	4	1
With Others	1	-
Totals	325	100

This pattern of living arrangements may be compared with the living arrangements prior to admission of residents in homes. The proportion of residents who lived alone prior to admission to a home was 46% - very similar to the home help recipients. However the proportion of residents who lived with a spouse prior to admission is much smaller at 6%. See Figure 7.

Figure 7. Living arrangements of Home Help Recipients and Residents.



Behaviour Rating

Table 15 shows the 5 physical dependency items from the Crichton Royal Behavioural Rating Scale. Each item is rated on a 5 point scale except feeding which is rated on a 4 point scale. Care should be exercised in interpreting the results in this section and the following section on Mental Disturbance as this behavioural rating

scale was designed for use with people resident in homes and hospitals and is dependent upon the respondent having direct knowledge of the individual concerned. However, as has been shown earlier most of the elderly people have been known to the social work assistants for more than 12 months.

Among home help recipients 80% were described as fully ambulant or usually independent and 14% as able to walk with aids, bedfast or chairfast. The corresponding figures for residents in homes were 61.% and 31%. The vast majority of home help recipients had no problems with dressing. Only 4% were described as inadequate unless continuously supervised and a further 4% as unable to dress or to retain clothing. In homes the corresponding figures were 12% and 10%. None of the home help recipients required feeding and 3%, 11 people, were described as inadequate unless continually supervised. Among residents in homes 1% required feeding and a further 7% were described as inadequate in this activity.

The activity in which the home help recipients were least proficient is bathing - 13% were described as requiring bathing. The corresponding figure for residents was 33%. Incontinence was not common among home help recipients - 4% were described as being incontinent of urine or doubly incontinent. In homes the corresponding figure was 10%.

Table 15 Physical Care Items

Physical Care Items	Home Help Recipients		Residents	
	No	%	No	%
Mobility				
Fully ambulant including stairs	130	40	103	35
Usually independent	130	40	77	26
Walks with supervision	20	6	27	9
Walks with aids or under careful supervision	33	10	70	24
Bedfast or chairfast	12	4	20	7
Dressing				
Correct	209	64	116	39
Imperfect but adequate	75	23	77	26
Adequate with minimum of supervision	16	5	38	13
Inadequate unless continually supervised	12	4	35	12
Unable to dress or to retain clothing	13	4	31	10
Feeding				
Correct unaided at appropriate times	283	87	205	69
Adequate with minimum supervision	29	9	68	23
Inadequate unless continually supervised	11	3	20	7
Requires feeding	2	-	4	1
Bathing				
Washes and bathes without assistance	190	58	20	7
Minimal supervision with bathing	61	19	76	26
Close supervision with bathing	24	7	67	23
Inadequate unless continually supervised	6	2	35	12
Requires bathing	44	13	99	33
Continence				
Full Control	243	75	178	60
Occasional accidents	61	19	67	23
Continent by day only if regularly toileted	9	3	22	7
Urinary incontinence in spite of regular toileting	6	2	26	9
Regular or frequent double incontinence	6	2	4	1

Table 16 shows the 5 mental disturbance items from the Crichton Royal Behavioural Rating Scale. Ratings on these items should be treated with some caution. While ratings are clearly related to measures of mental impairment, there is not necessarily a simple one to one correspondence. The scale measures the extent of disturbed behaviour reported by staff, which is obviously dependent on the level of contact with the client and the interpretation placed upon such behaviour. Thus, for example, it is probable that some individuals described as unable to communicate are deaf rather than confused. Nevertheless the results for individual items do indicate the extent to which staff perceived particular types of behaviour at presenting problems.

Table 16 Mental Disturbance Items

Mental Disturbance Items	Home Help Recipients		Residents	
	No	%	No	%
Memory				
Complete	245	75	128	43
Occasionally forgetful	63	19	85	29
Short-term loss	4	1	38	13
Short and long-term loss	13	4	46	15
Orientation				
Complete	272	84	144	48
Orientated in home, identifies people correctly	38	12	66	22
Misidentifies but can find way about	10	3	34	11
Cannot find way to bed or toilet without assistance	1	-	29	10
completely lost	4	1	24	8
Communication				
Always clear, retains information	277	85	119	40
Can indicate needs, understand simple verbal directions, can deal with simple information	42	13	140	47
Cannot understand simple verbal information or cannot indicate needs	2	-	13	4
Cannot understand simple verbal information and cannot indicate needs, retains some expressive ability	1	-	16	5
No effective contact	3	-	9	3
Restlessness				
None	264	81	169	57
Intermittent	84	17	101	34
Persistent by day or night	4	1	10	3
Persistent by day AND night	2	-	11	4
Constant	1	-	6	2
Co-operation				
Actively co-operative	293	90	115	39
Passively co-operative or occasionally unco-operative	26	8	115	39
Requires frequent encouragement or persuasion	5	1	54	18
Rejects assistance, shows independent ill directed activity	1	-	6	2
Completely resistive or withdrawn	0	0	7	2

Total Behaviour Rating

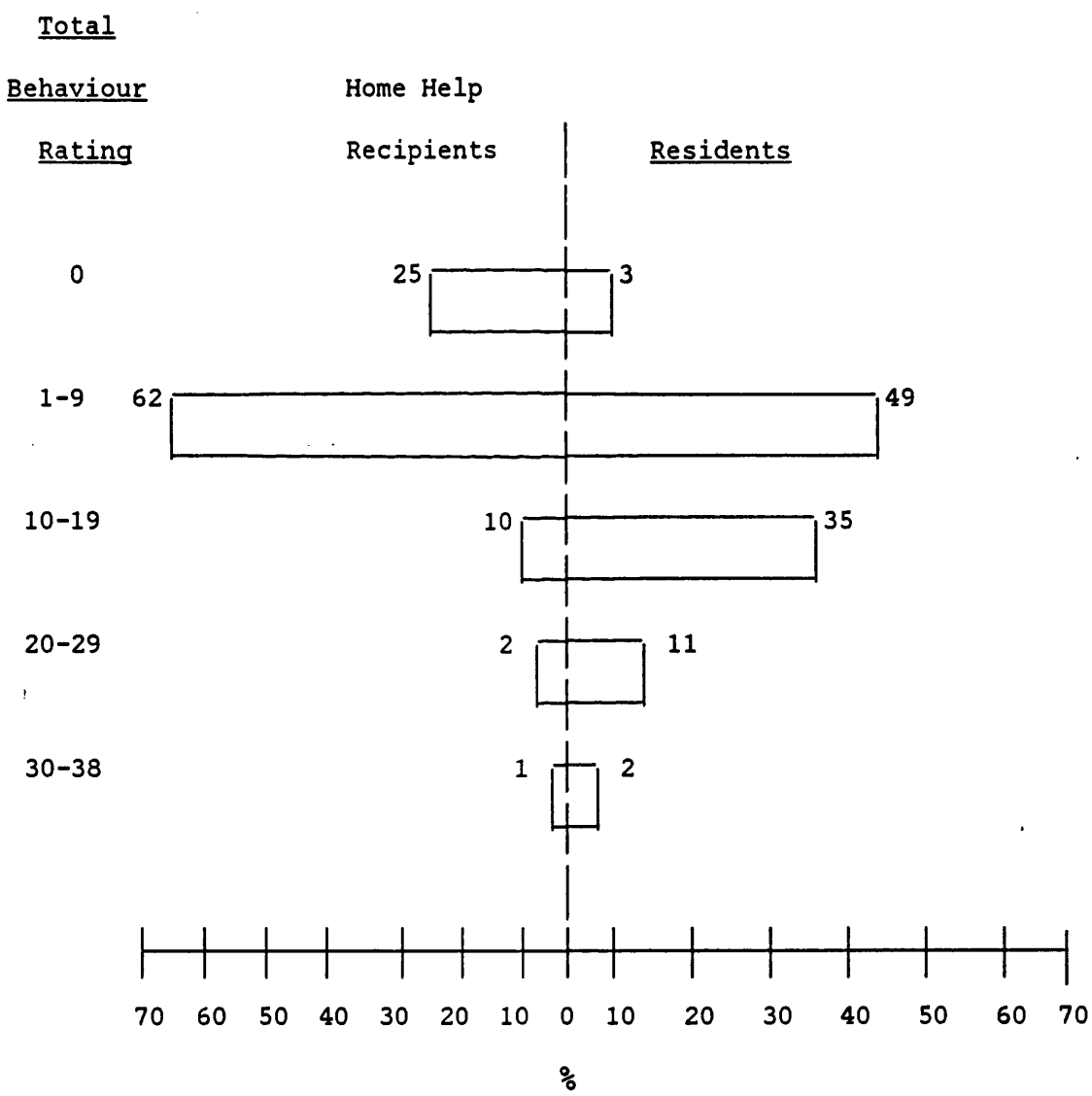
In Table 17 the 325 elderly recipients of the service are analysed by their total behaviour rating and their living arrangements. The total behaviour rating is what one would expect from the discussion of the individual items. 81 people (25%) scored 0, 202 people (62%) scored 1-9 and the remaining 42 people (13%) scored between 10 and 38. Among those scoring 0, 37 people, (6%), lived alone; among those scoring 1-9, 107 people, (53%), lived alone; and among the remainder, 9 people, (41%), lived alone.

Table 17. Recipients by Living Arrangements and Behaviour Rating

Behaviour Rating	Living Arrangements: Alone		Spouse Only		Spouse & Children		Children		Others		Totals	
	No	%	No	%	No	%	No	%	No	%	No	%
0	37	46	21	26	5	6	6	7	12	15	81	100
1-9	107	53	52	26	9	4	20	10	14	7	202	100
10-19	8	24	15	45	2	6	3	9	5	15	33	100
20-29	1	17	1	17	0	-	3	50	1	17	6	100
30-38	0	-	1	33	1	33	1	33	0	-	3	100

The total behaviour ratings for the elderly recipients of the home help service may be compared with that of the residents of homes in the district. Among 297 residents 10 people (3%) scored 0; 145 people (49%) scored 1-9 and 142 people (48%) scored 10-38.

Figure 8. Total Behaviour Rating of Home Help Recipients and Residents



The mean behaviour rating score for home help recipients was 4.16 and for residents 10.6.

Help Provided to Clients

The personal and domestic circumstances of the clients mean that a variety of tasks have to be performed to suit each individual case. These factors will be reflected in the amount of time allocated which in turn will be affected by the level of alternative help available.

Time Allocated

The allocation of time to a particular case will vary considerably depending upon assessment of need, sources if alternative help, and availability of resources. Some 40% of households received the service on 5 days per week and more than 1 in 5 households received the service on 7 days per week. In total almost three-quarters of households received the service on 5 or more days per week. At the other end of the scale only 2% of households received the service on one day per week. The number of days per week assistance is shown in Table 18 and is analysed further in Tables 19 and 20 which show the total behaviour rating of recipients and the number of days service received on week days and week-ends respectively.

Table 18. Household by Number of Days per Week of Service Provided

Number of Days	Number of Households	Relative Frequency %
1	5	2
2	29	11
3	28	10
4	15	6
5	106	40
6	25	9
7	59	22
Totals	267	100

Table 19. Recipients by Number of Days of Service Per Week and Total Behaviour Rating - Week Days

Total Behaviour Rating	Number of Days Service										Totals	
	1		2		3		4		5			
	No	%	No	%	No	%	No	%	No	%	No	%
0	1	1	19	23	14	17	6	7	41	51	81	100
1-9	4	2	17	9	22	11	13	7	146	73	199	100
10-19	0	0	0	0	2	6	0	0	31	94	33	100
20-29	0	0	0	0	1	17	0	0	5	83	6	100
30-38	0	0	1	33	0	0	0	0	2	67	3	100
Totals	5	2	37	11	39	12	19	6	225	69	325	100

Table 20. Recipients by Number of Days of Service and Total Behaviour Rating - Week-ends

Total Behaviour Rating	Number of Days Service						Totals	
	0		1		2			
	No	%	No	%	No	%	No	%
0	70	86	4	5	7	9	81	100
1-9	130	65	24	12	48	25	199	100
10-19	13	39	7	12	13	39	33	100
20-29	4	66	0		2	34	6	100
30-38	2	66	0	0	1	34	3	100
Totals	219	67	35	11	71	22	325	100

The average number of hours allocated to these households was 6.4 hours per week. The time allocated ranged from 2 hours to 4 households to 17 hours to 2 households. The most common allocation was 5 hours which was given to 96 households (36%). Only 15% of households had 10 or more hours per week. See Table 21.

Table 21. Households by Number of Hours Per Week of Service Provided

Number of Hours	Number of Households	Relative Frequency %
0-4	57	21
5-9	170	64
10-14	35	13
15-17	5	2
Totals	267	100

The hours allocated on week days and week-ends is analysed further by total behaviour rating in Tables 22 and 23. At week-ends the service was provided to 32% of recipients. 11% received the service for one hour, 20% for 2 hours and 1% for 3 or 4 hours.

Table 22. Recipients by Hours Worked and Behaviour Rating - Week Days

Total Behaviour Rating	Hours Worked							
	0-4		5-10		11-16		Totals	
	No	%	No	%	No	%	No	%
0	30	37	49	60	2	3	81	100
1-9	39	19	154	76	9	5	202	100
10-19	1	3	27	82	5	15	33	100
20-29	0	0	6	100	0	0	6	100
30-38	1	34	2	66	0	0	3	100
Totals	71	22	238	73	16	5	325	100

Table 23. Recipients by Hours Worked and Behaviour Rating - Week-ends

Behaviour Rating	Hours Worked											
	0		1		2		3		4		Totals	
	No	%	No	%	No	%	No	%	No	%	No	%
0	70	86	5	6	6	8	0	0	0	0	81	100
1-9	131	65	28	14	42	21	0	0	1	-	202	100
10-19	13	39	3	9	14	42	3	9	0	0	33	100
20-29	4	66	0	0	2	34	0	0	0	0	6	100
30-38	2	66	0	0	1	34	0	0	0	0	3	100
Totals	220	68	36	11	65	20	3	1	1	-	325	100

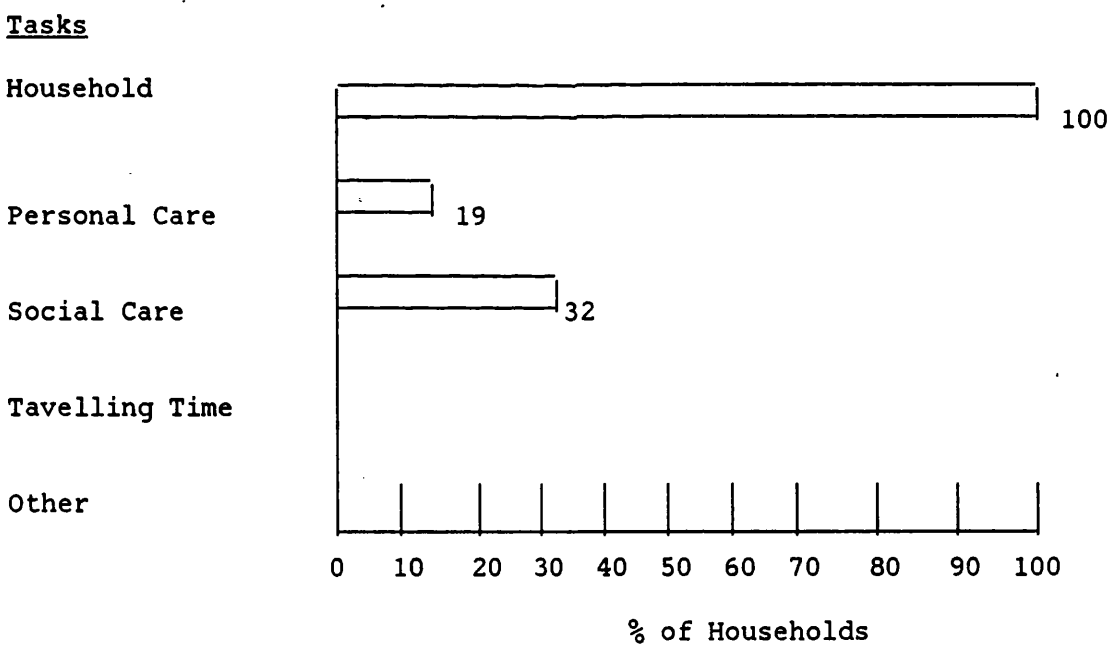
Tasks Performed

Respondents were asked to identify the hours allocated to 3 areas of work identified by the Central Personal Social Services Advisory Committee's Subcommittee on the Administration of the home help service as appropriate to home helps - household tasks, personal care tasks and social care tasks. All households were receiving hours for household tasks ranging from one hour in one household to 14 hours in another. The most common allocation was 5 hours to 27% of households. 30% of households had less than 5 hours per week for household tasks and only 6% of households had 10 or more hours per week. Over 80% of households had no hours allocated for personal care tasks. 11% of households had one hour per week for this activity and at the other end of the scale only one household had 6 hours per week. For social care tasks some 67% of households had no hours allocated, 20% had one hour per week and 6% 2 hours per week. See Table 24 and Figure 9.

Table 24. Hours per Week Allocated to Different Tasks

	Tasks					
Hours	Household		Personal Care		Social Care	
	No	%	No	%	No	%
0	0		216	81	179	67
1	1		30	11	70	26
2	4	2	12	4	17	6
3	22	8	1	-	1	-
4	52	20	3	1		
5	71	27	4	2		
6	36	14	1	-		
7	31	12				
8	20	8				
9	11	4				
10	8	3				
11	1	-				
12	5	2				
13	3	1				
14	1	-				
Totals	266	100	267	100	267	100

Figure 9. Allocation of Time to Different Tasks



Although it is difficult to categorise all tasks that could be carried out by home helps the Subcommittee identified a number of tasks under the different areas of work. It is perhaps not surprising that, among the household tasks, the one most frequently performed task was that of cleaning the house, the second most frequently performed task was that of washing and ironing clothes, and the third most frequent was making beds. In addition, washing up; lighting fires and bringing in fuel; and preparing and cooking food was carried out for more than half the households. See Figure 10.

Figure 10. Household Tasks Performed by Home Helps

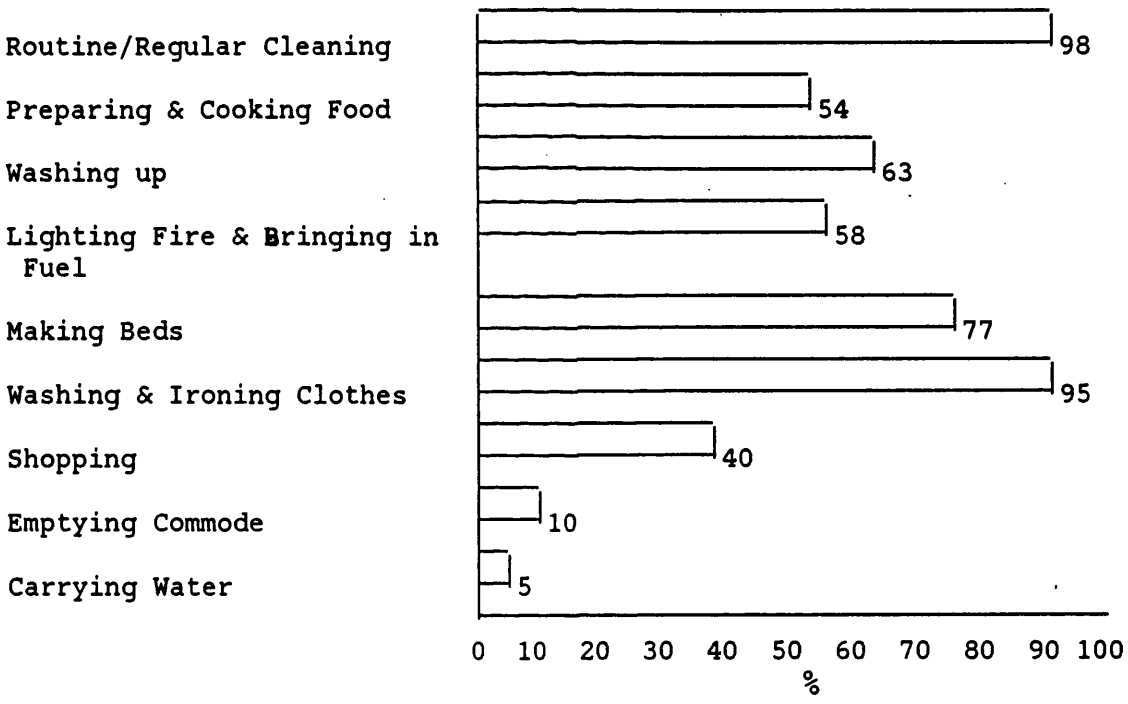
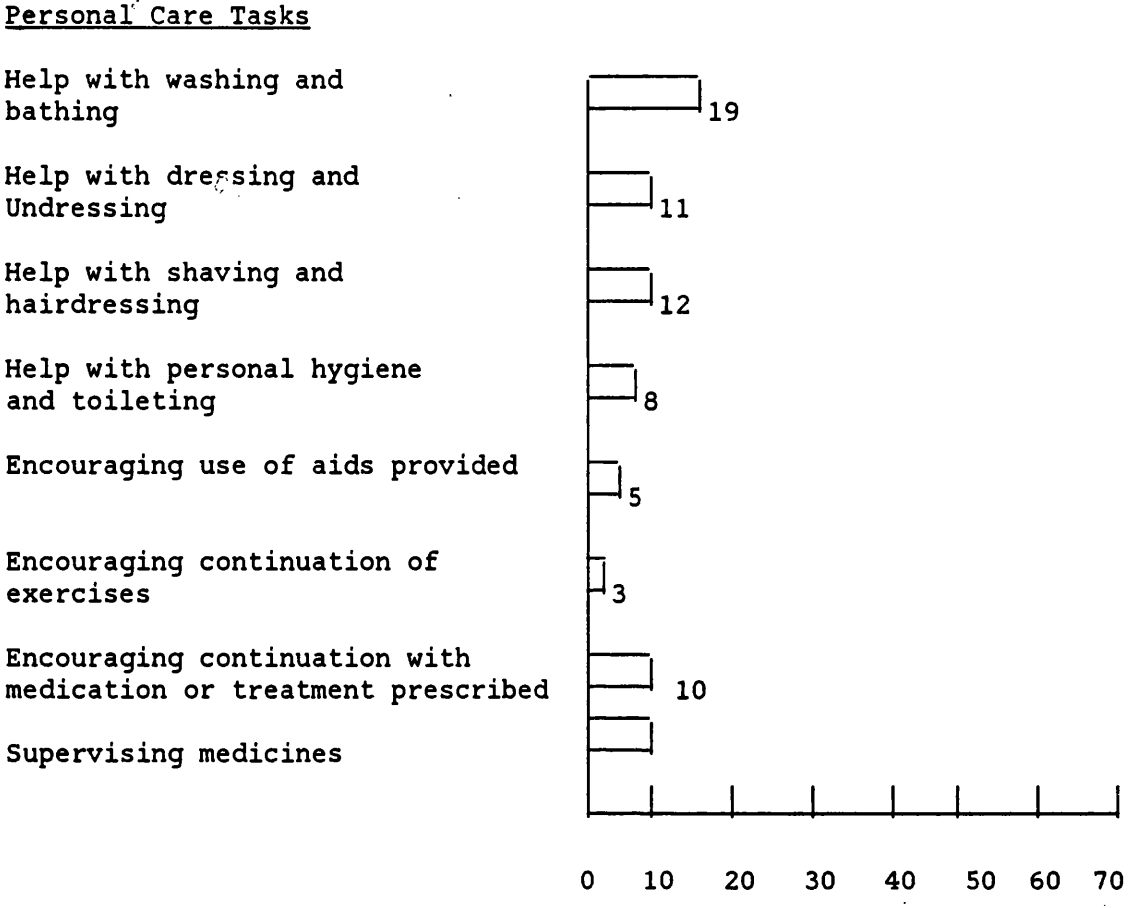


Table 25. Recipients by Household Tasks Performed and Behaviour Rating

Household Tasks	Behaviour Rating										Totals	
	0		1-9		10-19		20-29		30-38			
	No	%	No	%	No	%	No	%	No	%	No	%
Cleaning	80	25	199	62	33	10	6	2	2	-	320	100
Preparing/ Cooking Food	30	17	115	67	23	13	3	2	1	-	172	100
Washing Up	38	18	134	65	28	14	5	2	1	-	206	100
Lighting Fire	32	17	127	69	21	11	2	1	1	-	183	100
Making Beds	53	21	161	65	29	12	5	2	1	-	249	100
Washing/ Ironing	77	25	193	62	33	11	6	2	2	-	311	100
Shopping	18	14	91	72	17	13	0	0	1	-	127	100
Emptying Commode	4	13	19	60	7	22	1	3	1	3	32	100
Carrying Water	3	19	11	69	1	6	1	6	0	0	16	100

Only 19% of all households received help with personal care tasks. The most common form of help was for washing and bathing, 19%, followed by shaving and hairdressing, 12%. See Figure 11.

Figure 11. Personal Care Tasks Performed by Home Helps



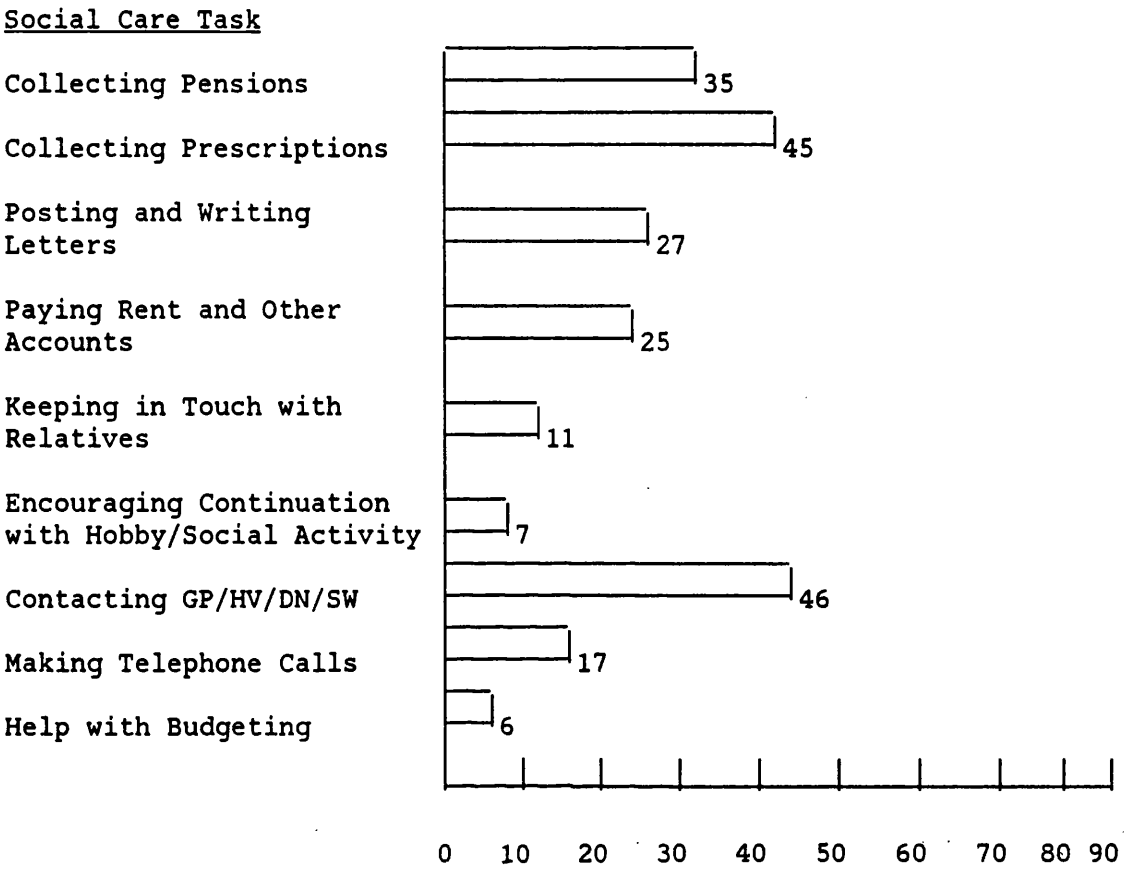
The recipients of assistance with personal care tasks are analysed further by total behaviour rating and the hours allocated to the tasks in Table 26.

Table 26. Recipients by Hours Allocated to Personal Care Tasks and Behaviour Rating

	Behaviour Rating									
HOURS	0		1-9		10-19		20-29		30-38		Totals	
	No	%	No	%	No	%	No	%	No	%	No	%
0	77	30	162	63	18	7	1	-	2	-	260	100
Up to 1	3	8	30	77	6	15	0	0	0	0	39	100
1-2	1	6	9	56	4	25	2	13	0	0	16	100
2-4	0	0	0	0	2	50	2	50	0	0	4	100
4-6	0	0	1	20	3	60	1	20	0	0	5	100
6-8	0	0	0	0	0	0	0	0	1	100	1	100
Totals	81	25	202	62	33	10	6	2	3	1	325	100

Among the range of social care tasks identified and with which 32% of households were receiving assistance the most commonly performed was contacting general practitioner/health visitor/district nurse/social worker. This was closely followed by collecting prescriptions 45% and collecting pensions 35%. Over one-quarter of households received help with posting letters and paying rent and other accounts. See Figure 12.

Figure 12. Social Care Tasks Performed by Home Helps



The recipients of assistance with social care tasks are analysed further by total behaviour rating and hours allocated to the task in Table 27.

Table 27. Recipients by Hours Allocated to Social Care Tasks and Behaviour Rating

Hours	Behaviour Rating										Totals	
	0		1-9		10-19		20-29		30-38			
	No	%	No	%	No	%	No	%	No	%	No	%
0	66	31	126	58	18	8	4	2	2	1	216	100
up to 1	14	16	60	71	10	12	1	1	0	0	85	100
1-2	1	4	16	70	4	17	1	4	1	4	23	100
2-3	0	0	0	0	1	100	0	0	0	0	1	100

Respondents were asked to identify if there was any difference between the actual hours allocated to a household and the hours needed. Replies to this question are shown in Table 28. In almost 80% of cases there was no difference but in some 16% of cases (44 households) there was a difference due to the number of hours available in the district being insufficient.

Table 28. Major Reason for the Difference between Actual Hours and Hours Needed

Major Reason	No	%
No Difference	212	79
Household Unwilling to Afford More	0	0
Household Unwilling to Receive More	2	1
Local Shortage of Home Helps	1	1
Insufficient Hours in District	44	16
Other	8	3

The home help service is often one of a package of services provided to help people stay in their own homes. Apart from visits from a social work assistant large numbers of recipients of the service did not receive many other services. 32% received visits from a voluntary helper/visitor, 17% received visits from a district nurse and 10% meals-on-wheels and visits from a health visitor. See Table 29.

Table 29. Provision of Other Help

Other Services Provided	No	%
None	3	-
Visits from Social Worker	8	2
Visits from Social Work Assistant	309	95
Nightsitter	0	0
Luncheon Club	13	4
Meals-on-Wheels	31	10
Day Centre/Social Club	23	7
Laundry	6	2
Voluntary Help/Visitors	105	32
Visits from Health Visitor	33	10
Visits from District Nurse	54	17
Bath Attendant	1	-
Sheltered Dwelling Warden	1	-
Occupational Therapist	0	0
Chiropodist	4	1
Other	8	2

Social work assistants were asked to identify those recipients who were not most suitably placed at home and among the 325 elderly people in receipt of the home help service, 17 people (4%) were identified as requiring some other form of care. The services required by the 17 people are shown in Table 30. The alternatives suggested were only being sought in 3 cases.

Table 30. Recipients by Most Appropriate Alternative Placement

Most Appropriate Placement	No	%
Sheltered Housing	4	23
Old People's Home	8	47
EMI Home	2	12
Geriatric Ward	2	12
Psychogeriatric Ward	1	6
	17	100

Finally social work assistants were asked to identify those elderly people who were in receipt of Attendance Allowance and to indicate if the availablility of this allowance reduced the hours allocated to the household. Among the 267 households attendance allowance was being paid to 34 households and in 10 cases the hours of service allocated had been reduced. In 2 households the hours were reduced by 2 hours per week and in one household by 15 hours per week. In total the hours to the 10 households were reduced by 52 hours - an average of 5.2 per week. See Table 31.

Table 31. Households in Receipt of Attendance Allowance by Hours Reduced

No of Households	No of Hours per week reduced	Total No of Hours per week reduced
2	2	4
2	3	6
2	4	8
1	5	5
1	6	6
1	10	10
1	13	13
10	-	52

THE DECISION-MAKING PROCESS

As mentioned earlier only one district participated in this part of the study. This district covers the geographical area of 3 District Councils and the sub-offices for the administration of the home help service correspond to these areas. They are Londonderry, Limavady and Strabane. Although there are 3 sub-offices in Londonderry District Council's area there is one home help organiser in this sub area who manages the home help service. See organisation chart attached as Annexe I.

Staffing

In the Londonderry sub area there are 19 social work assistants involved in the delivery of the home help service. They are managed by a system of assistant principal social workers and team leaders (senior social workers). The home help organiser is assisted by 2 clerical staff. In Limavady the office is managed by an assistant principal social worker who also acts as a team leader with a senior social worker, a social worker and a social work assistant in his team. In addition there is a team leader with 4 social workers (one specialising in work with the mentally handicapped) and 3 social work assistants. The professional staff are supported by a clerical officer, 3 personal secretaries and 1 part-time clerical officer for the home help service. In Strabane the office is managed by an assistant principal social worker and 2 team leaders. One team leader is responsible for family and child care services and has under his control 4 social workers. The other team leader has responsibility for services for the elderly, physically handicapped, mentally

ill and health care in addition to her responsibility for organising the home help service. Under her control she has 2 social workers, 1 dealing with the mentally handicapped and 1 attached to the health centre. In addition she has a group of 9 social work assistants (5 full-time and 4 part-time).

Procedure

The procedure for dealing with applications in Londonderry is as follows. If the initial request for the service is made to the home help organiser she refers the matter to a team leader to allocate to a social work assistant. If the request is made direct to the sub-office the team leader will allocate the case to social work assistants on the basis of the number of cases they currently have on their case-load. The social work assistant will then visit and complete the necessary forms. Following the initial visit the social work assistant submits the documentation to the home help organiser giving brief details of any handicap or illness suffered by the applicant and a brief social report. The home help organiser then allocates the number of hours and days on which the service may be provided. In Limavady all initial referrals are directed to the intake worker and the clerical staff, and details are entered in a referral book. If the person is already known to the department the file is attached to the referral book and if not known a new file is opened. Allocation meetings are held once weekly and in addition to dealing with new referrals the meeting is used to provide information about earlier referrals and the current cases. Following the allocation meeting the social work assistant then makes contact with

the applicant, completes application forms, makes an assessment of the situation and if it is urgent may start a home help immediately. If the case is not urgent the information is brought back to the allocation meeting which is held every Thursday morning and which is attended by the assistant principal social worker, the team leader and all social work assistants. The social work assistants report on each new case, make a recommendation about the number of hours they think is necessary and an agreement is sought among all the staff on the allocation of hours for each case. Following the agreement on the number of hours the social work assistant then makes arrangements with the administrative staff for starting the home help. In Strabane the procedure for dealing with applications for home helps is as follows:

a. new referrals from whatever source are noted in the referral book;

b. the referral book is examined each day by the the team leader;

c. cases are allocated once weekly at a team meeting with the social work assistants who work on a geographical patch basis;

d. a team meeting deals with the allocation of cases and the allocation or review of hours of the home help service;

e. after being allocated a particular case the social work assistant will visit the applicant, complete an application form and assess the need for the service. If there is no apparent need the social work assistant will give an immediate decision to the applicant.

If there is no apparent need but the social work assistant has some doubt she will discuss this with her team leader before giving a decision to the applicant. If there is a need and it is considered urgent the social work assistant will discuss the case with the team leader and then allocate an agreed number of hours. If the need is accepted but is not considered urgent the case will be referred to the next week's team meeting.

Allocation decision

In Londonderry the need for a case is assessed by the social work assistant and endorsed by the home help organiser. However, the home help organiser insists that she has the right to visit any case and to make her own assessment if she feels this is necessary. In Strabane the allocation decision is based on a consensus among all staff attending the allocation meeting. However, the overriding decision rests with the assistant principal social worker - the office manager. In Strabane the decision to allocate the service and the number of hours of service to be allocated is not undertaken by the social work assistant alone. There is always discussion with the team leader. The team leader takes the final decision based on the social work assistant's report and her assessment of the number of hours needed which is set against the number of hours the team leader has available to allocate to new places.

Number of Home Helps in the District

At the time of the interview (March 1983) there were approximately 1350 part-time home helps employed in the district. These were distributed as follows:- Londonderry, 600; Strabane, 470 and Limavady, 287.

Number of Households covered in the District.

At the time of the interviews there were approximately 2140 households receiving a service. These were distributed as follows: Londonderry, 1200; Strabane 550; Limavady, 390.

Number of hours allocated to districts

Information given to the interviewer suggests that the district had an allocation of 11,275 hours of service per week (whole time equivalent of 282). These hours were distributed as follows: Londonderry 5100; Limavady 2300; Strabane 3875. Among the 3 sub-districts the Londonderry sub-district was grossly overspent on its home help budget - using an additional 1200 hours over its allocation.

The Health and Personal Social Services (Northern Ireland) Order 1972

The managers were asked if the Health and Personal Social Services Order helped in the decision-making process for the allocation of the service. The general response was that the managers were aware of the Order but that it was not significant apart from providing legal cover for the provision of the service by a Board.

Circulars/Guidance

The managers were also asked if there were any circulars/notes of guidance issued by the Department or the Western Board which assisted in determining the allocation of the service. All indicated that apart from the model scheme issued by the department there was no such guidance.

Presence of a carer

The managers were asked if, when deciding on the allocation of the service, consideration was taken of the person/people caring for the elderly person and, if so, what factors were taken into account. In Londonderry the organiser was adamant that consideration was taken of the carers, not only those living in the household but relatives who may be living nearby. This was especially the case when considering the provision of service at week-ends or during holiday periods. She was of the opinion that the presence of a carer did not necessarily give a lower priority for the service especially if the carer was male.

In Strabane the team leader indicated that when deciding on the allocation of the service consideration was taken of the presence of a carer. She was unable to be specific about the factors which were taken into account and indicated that the presence of a carer did not mean that a case was given a lower priority. In Limavady the manager there indicated that consideration was taken of the person/people caring for the elderly person. This was especially so in cases where a relative was in residence in the same household. Factors which would be taken into account were the relationship and proximity/availability of the relative as well as the number of relatives. He acknowledged that some people were unwilling to care for relatives and took no interest in their situation. He indicated that the presence of a relative did give a lower priority for the provision of service and suggested that where there was an unemployed member of the household this was taken into account in deciding the number of hours.

Alternatives

When asked if alternatives to the home help service were considered the home help organiser in Londonderry stated that the only alternative suggested was attendance at a day centre allied to a partial provision of the home help service together with meals-on-wheels. A small laundry service is also available in this part of the district. In Limavady the manager there suggested that other services may be given in addition to the home help service rather than as alternatives. For example he suggested that if a person could receive day care at a day centre or old people's home then he could manage with a smaller number of home help hours. A local old people's home was used for day care purposes. In Strabane it was suggested that alternatives were only considered in a small number of cases. Among the alternatives considered would be day care at an old people's home or in a day centre. Day care in an old people's home was likely to be considered appropriate if the old person required a high degree of physical care, and day care at a day centre if the old person was in need of socialisation, and if relatives caring for the elderly person required some relief. Similar considerations apply to attendances at luncheon clubs.

Waiting list

There are no waiting lists for the service operating in any of the 3 sub-districts. The home help organiser in Londonderry stated that she would not wish to see a waiting list operate and goes to considerable length to ensure that any new applicant receives a service. In Strabane no new applications for the home help service were processed

during the period September to December 1982 and all new applicants were advised that home help time was not available. This led to a backlog of approximately 30 to 40 cases for a short period of time.

Local policy statement

All 3 managers indicated that there was no formal statement of policy which is available to staff and/or the public.

Priorities

In Londonderry the home help organiser stated that there were no priorities in service provision. Anyone who made an application and who was considered to be in need would be provided with a service even at a very low level. In Limavady the manager there suggested that the elderly who are isolated and living alone would be given first priority. No priority groups were identified in Strabane.

Review procedures

In Londonderry cases are reviewed on the basis that if a financial assessment is made the case will be reviewed every 3 months, and if no financial assessment has been made, every 6 months. At the time of this interview reviews were suspended on the basis of a heavy workload being undertaken by social work assistants. In Limavady there are no regular review procedures operating and in Strabane reviews are undertaken at the regular team meeting which is held each week. However, there is no systematic process of reviews and the need for review is dictated by changing circumstances in each case. Each case is usually visited once every 3 months but in some cases there may be reviews of new cases after 4 to 6 weeks of service.

Definition of risk

In Londonderry the home help organiser was not clear in her definition of the term "at risk". She referred to it as applying to people who were elderly or physically handicapped and those suffering from epilepsy and those elderly who were confused. She suggested that there was considerable risk in leaving confused elderly people at night because they were prone to wander. The manager in Limavady confined "at risk" to those elderly people living alone qualified by the physical setting in which they are living. In Strabane the manager takes into account the physical, social and emotional factors as well as the environment in which the old person is living. As well as the opinion of social services staff opinion is sought from other professionals involved eg doctors and nurses.

The managers were then asked if they considered a person to be more "at risk" and therefore have a better chance of receiving the service if his needs were of a physical nature (self care ability, general and mental health) rather than of a social nature (loneliness, social isolation). All 3 indicated that a person was more "at risk" and therefore had a greater chance of receiving the service if his needs were of a physical nature rather than of a social nature. One felt that social needs were more likely to be met at a day centre but if a person was reluctant to attend a day centre the home help service might be considered appropriate to meet social need.

An alternative to residential care?

The managers were asked if they considered the home help service as providing an acceptable alternative to residential care. Opinion on

this was divided. The home help organiser viewed the home help service as providing an acceptable alternative to residential care. This was based on her view that elderly people should be kept in the community for as long as possible. Even if the social services department could only provide a low level of service, this should be provided despite the fact that some people could do with more hours to ensure a better quality of life outside residential care. In Strabane the manager there was of the opinion that the home help service was providing an acceptable alternative to residential care as it enabled a number of elderly people to cope in the community within their own home and that this still applied even with a small number of hours of service. She was of the opinion that in many cases the home help provided a substitute family for many elderly people living alone and that the home help could bring a whole range of informal care to the elderly person. The manager in Limavady, however, doubted whether the home help service could be seen as providing an acceptable alternative to residential care. He saw the home help service as trying to give individuals a degree of independence. The number of hours being given could not be seen as providing an acceptable alternative to residential care.

Applications rejected

The managers were asked to indicate how many applications for the service had been rejected during the past 12 months. Two managers, in Londonderry and Strabane, indicated that no applications for the service had been rejected but a small number of people had refused the service because they were unwilling to pay the charge for the service. In Limavady during the 12 months ending December 1982 the sub-district had received 124 applications. Seventy-six of these were approved and 48 not approved. However, only 2 of these cases were rejected by the social services staff, one on the grounds that a husband who was unemployed was available to help his pregnant wife and in the other cases relatives were living nearby. In the other cases the applicants had been referred by others eg hospital staff and did not wish to proceed with their application for the service when interviewed.

CHAPTER 7

CASE STUDY 2 - RESIDENTIAL ACCOMMODATION

In the area of the Western Health and Social Services Board there were 13 homes providing 548 places distributed throughout the districts in the following way:-

Londonderry, Limavady & Strabane	: 8 homes - 320 places
Omagh	: 2 homes - 91 places
Fermanagh	: 3 homes - 137 places.

In this Chapter the results of the residential care case study will be presented in 3 sections:-

1. current residents;
2. admissions; and
3. policies, procedures and decision-making.

1. CURRENT RESIDENTS

The main objective of this section is to describe the characteristics of elderly people in residential care in the Western Board's area, to compare the different Districts in terms of the pattern of problems presented by their residents and to consider how appropriately people were placed in the range of facilities available. In addition to presenting the data from the Western Board the chapter will present information from a similar study of residential care in another District within the Eastern Board conducted in 1980(1) thereby enabling some comparisons to be made between authorities. As well as making this comparison an attempt will be made to relate the information from this study to some of the information obtained from a study of residents in homes for the elderly throughout Northern Ireland conducted in 1976(2). This should enable some comparisons to be made between the group of residents being cared for within the Western Board's area in 1976 and 1982.

Age

In recent UK Studies of existing residents of homes for the elderly the proportion of residents over 84 years of age reported varied between 29% and 43% compared with 6.7% in the over 65s as a whole. Among the total elderly population (age 65 and over) in the Western Board's area, 64.3% were aged between 65 and 74 years, 29.4% were aged between 75 and 84 years and 6.3% were aged 85 years and over. Table 1 shows the age distribution of the residents in the Districts and in the Board. In the Homes 22%

were aged between 65 and 74 years, 46% were aged between 75 and 84 years and 28% aged 85 years and over. Overall this last figure was lower than any other study and considerably lower than the proportion over 84 years (39%) reported in East Belfast and Castlereagh. However there are substantial differences between Districts within the Board. In the homes in Omagh 38% of residents were over 84 years, in Fermanagh 30% and in Londonderry, Limavady and Strabane 24%. The corresponding figures for the total elderly population for these Districts were 7%, 6.6% and 5.9%.

Table 1: Residents by Age and District

	District									
Age	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Under 65	15	5	1	1	4	3	20	4	-	-
65-74	62	21	26	30	27	20	115	22	30	13
75-84	148	50	28	32	61	46	237	46	115	48
85+	72	24	33	38	40	30	145	28	93	39
TOTALS	297	100	88	100	132	100	517	100	238	100

Sex

Most, but not all recent studies of residents report the sex distribution in homes. All show a preponderance of women, the percentage varying from 59% to 78%. Later studies tend to show a higher proportion of women. The sex distribution of residents tends to reflect the age distribution, in that the very old are more likely to be cared for in residential homes and this age group contains a much higher proportion of women than men. Among the total elderly population in the Western Board's area 55% were female but among the group aged 85 years and over the proportion increased to 61%. In the Old People's Homes 63% of all residents are female which was considerably less than the proportion found in the homes in East Belfast and Castlereagh - 86%. See Table 2.

Table 2: Residents by Sex and District

	District									
Sex	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Male	100	34	32	36	59	45	191	37	33	14
Female	197	66	56	64	73	55	326	63	205	86
TOTALS	297	100	88	100	132	100	517	100	238	100

The age and sex distribution in homes in the Western Board is considered further in Table 3 which shows the age and sex of all residents in 1976 and 1982. In 1976 53% of residents were male, 47% female but by 1982 the pattern had changed considerably. The proportion of males in homes had fallen to 37% and the proportion of women had risen to 63%. Within each group the age pattern had altered also. In 1976 33% of male residents were in the youngest age range, 65-74 years, and 22% in the oldest age range 85 years and over. The proportion in the oldest age range had remained steady but the proportion in the youngest age range had fallen and had been offset by an increase in the proportion in the middle age range. Movement among the female group had been different. The proportion of very old women had increased as had the proportion of women in the middle age range leading to a decline in the proportion of women in the youngest age range.

Table 3: Comparison of Total Residents between 1976 and 1982 by Age and Sex

	1976		1982	
	Male	Female	Male	Female
Age	%	%	%	%
Under 65	6	6	6	3
65-74	33	26	25	21
75-84	39	41	48	45
85+	22	28	22	32
N=	175	165	191	326

Marital Status

Among the total elderly population in the Western Board's area 25% were single, 32% were widowed and 43% were married. Table 4 shows the marital status of those in homes for the elderly. Throughout the Board's area the single and widowed were over-represented but showed a markedly different picture from East Belfast and Castlereagh where only 31% were single compared with 52% for the Western Board and 58% were widowed compared with 41% for the Western Board.

Table 4: Residents by Marital Status and District

Marital Status	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Single	140	47	54	61	76	58	270	52	73	31
Married	19	6	1	1	5	4	25	5	23	10
Widowed	131	44	32	36	49	37	212	41	138	58
Separated /Divorced	6	2	1	1	2	2	9	2	4	2
Not known	1	-	0	-	0	-	1	-	0	-
TOTALS	297	100	88	100	132	100	517	100	238	100

Marital status and sex are examined in Table 5 and comparisons made between the total elderly residents in Board Homes in 1976 and 1982. In 1976 63% of male residents were single compared to 60% in 1982; the proportion who were widowed remained the same at 30% and the proportion who are married had increased from 1% to 3%. Among female residents the proportion who were single had fallen from 52% to 48%; the proportion who were widowed had remained the same at 48% and the proportion who were married had risen from 2% to 3%.

Table 5: Comparison of total Residents between 1976-1982 by Marital Status and Sex

	1976		1982	
Marital Status	Male	Female	Male	Female
	%	%	%	%
Single	63	52	60	48
Married	1	2	3	3
Widowed	30	48	30	48
Separated/Divorced	6	-	7	1
Not Known	-	-	-	-
N=	175	165	191	326

Length of Stay

Table 6 shows the length of stay by district. Throughout the Board 13% of all residents had been in homes for less than 6 months and at the other end of the scale just under one-third of all residents (31%) had been in homes for 5 or more years. The corresponding figures for East Belfast and Castlereagh were 20% and 24%. The proportion staying for long periods was similar in Londonderry, Limavady and Strabane and Fermanagh Districts at 33% but a quite different proportion was shown for Omagh - 19%. Two factors may help to explain this. The first is that Omagh has only 2 Old People's Homes, one of which was opened in the recent past. Secondly, and perhaps a more important factor, is that there were no old people in the youngest age band, 65-74 years, on the waiting list for residential accommodation in Omagh District, where as in Londonderry, Limavady and Strabane and Fermanagh some 40% of applicants for the residential accommodation were in this age range.

Table 6: Residents by Length of Stay and District

Length of Stay	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Less than 6 Months	47	16	8	9	14	11	69	13	47	20
7-12 Months	36	12	6	7	18	14	60	12	15	6
1-4 Years	116	39	57	65	57	43	230	44	120	50
5+ Years	98	33	17	19	43	33	158	31	56	24
TOTALS	297	100	88	100	132	100	517	100	238	100

The length of stay of male and female residents is examined further in Table 7 in both 1976 and 1982. In 1976 the proportion of male and female residents who had been in the home for less than 6 months was the same - 12%, but a higher proportion of males (35%) had been resident for more than 5 years. By 1982 the proportion staying for more than 5 years had declined with corresponding increases in the proportions being resident for shorter periods.

Table 7: Comparison of Total Residents Between 1976 and 1982 by Length of Stay and Sex

	1976		1982	
Length of Stay	Male	Female	Male	Female
	%	%	%	%
Less than 6 Months	12	12	14	13
7 Months-4 Years	53	56	55	57
5 Years or More	35	32	31	30
N=	175	165	191	326

Place from which Admitted

Information was collected about the person's address prior to admission. Overall 43% of residents were admitted from their own homes and 33% from some form of hospital provision. There were variations between Districts, the most noticeable being the 56% of admissions from "own home" in Omagh and the 40% of "hospital" admissions in Fermanagh. There was also considerable differences between the Board and East Belfast and Castlereagh where only 29% of admissions were from the resident's own home and 37% from hospital provision. See Table 8.

Table 8: Place from which Admitted by District

Place from which Admitted	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Own Home	111	37	49	56	56	42	216	42	61	26
Own Home with Warden	4	1	0	-	0	-	4	1	6	3
Home of Son or Daughter	20	7	7	8	3	2	30	6	12	5
Old People's Home Board	26	9	2	2	4	3	32	6	26	11
Old People's Home - Vol/Pri	2	1	0	-	0	-	2	-	7	3
EMI Home	1	-	0	-	0	-	1	-	3	1
Geriatric Ward	61	21	5	6	28	21	94	18	35	15
Psychiatric Ward	17	6	6	7	6	5	29	6	20	8
Psychogeriatric Ward	0	-	10	11	0	-	10	2	6	3
Other Hospital Ward	16	5	2	2	18	14	36	7	27	11
Nursing Home	0	-	0	-	0	-	0	-	6	3
Other	37	12	7	8	17	13	61	12	28	12
Not Known	2	1	0	-	0	-	2	-	1	-
TOTALS	297	100	88	100	132	100	517	100	238	100

Living Arrangements

Table 9 shows the living arrangements prior to admission to the home and reflects the living arrangements which pertained even if the person had been transferred from one institution to another. In all districts the highest proportion of residents lived alone and if one combined this with those living with a spouse these residents accounted for more than half of all admissions. This pattern was common to both the Western Board and East Belfast and Castlereagh.

Table 9: Residents by Living Arrangements Prior to Admission and District

Living Arrangements	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Alone	138	46	36	41	62	47	236	46	101	42
With Spouse Only	17	6	3	3	5	4	25	5	20	8
With Spouse and Children	3	1	3	3	1	1	7	1	3	1
With Children	41	14	11	13	15	11	67	13	33	14
With Brothers and Sisters	42	14	12	14	31	23	85	16	24	10
With Other Relations	26	9	11	13	10	8	47	9	13	5
With Others	23	8	12	14	5	4	40	8	20	8
Not Known	7	2	0	-	3	2	10	2	24	10
TOTALS	297	100	88	100	132	100	517	100	238	100

Catchment Areas

The figures in Table 10 show the Health and Social Services District in which the person was resident prior to admission. These reflect the catchment areas of the homes and show that there was little cross-boundary flow between the districts.

Table 10: Residents by District of Origin

	District							
District of Origin	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board	
	No	%	No	%	No	%	No	%
Londonderry, Limavady and Strabane	267	90	1	1	0	-	268	52
Omagh	7	2	76	86	0	-	83	16
Fermanagh	0	-	3	3	130	98	133	26
Other NI area	9	3	6	7	0	-	15	3
Republic of Ireland	3	1	0	-	1	1	4	1
Other	11	4	2	2	1	1	14	3
TOTALS	297	100	88	100	132	100	517	100

Physical Dependency

Table 11 shows the 5 physical dependency items from the Crichton Royal Behavioural Rating Scale. Each item was rated on a 5 point scale, except feeding which was rated on a 4 point scale. The ratings reflect the physical care which staff in the different types of units provided for the elderly people in their care.

The proportion of non-ambulant individuals throughout the Board's homes was similar to the proportion found in East Belfast and Castlereagh homes - 8%. However, by far the largest proportion of non-ambulant individuals was found in Omagh District where 13% of the residents were rated as non-ambulant. In addition a further 44% were reported as walking with aids or under careful supervision. In 1976 less than the 2% of residents in the Western Board were reported as being bedfast and just over 15% were described as walking only with support/chair bound.

The next 3 items in the table deal with aspects of self care - dressing, feeding and bathing. In all districts dressing presented a problem and this was especially so in Omagh District where 31% of residents required continual supervision or were unable to dress. Figures for the whole Board and East Belfast and Castlereagh were 17% and 36% respectively. A similar pattern emerged with regard to feeding with all districts experiencing difficulties, the heaviest burden fell on Omagh where 30% of residents required close supervision or required feeding. Corresponding figures for the whole Board and East Belfast

and Castlereagh were 11% and 8%. The pattern with regard to bathing was that all districts experienced considerable difficulty with this activity. Londonderry, Limavady and Strabane District experienced the least difficulty with 45% of residents requiring supervision or bathing while in Omagh 61% required this level of help. In East Belfast and Castlereagh the proportion was 70%.

Finally Table 11 shows the numbers of incontinent residents. The proportion of people who had full control was similar between the Board and East Belfast and Castlereagh with 55% and 54% respectively. However, Omagh District reported that only 23% of their residents had full control. In 1976 some 62% of residents in the Western Board's homes were described as always continent. At the other end of the scale the proportion of those described as doubly incontinent was 2% in the Western Board and 5% in East Belfast and Castlereagh. In 1976 in the Western Board homes 7% of residents were described as doubly incontinent.

Mental Disturbance

Table 12 shows the 5 mental disturbance items from the Crichton Royal Behavioural Rating Scale. Ratings on these items should be treated with some caution. While ratings are clearly related to measures of mental impairment there is not necessarily a simple one to one correspondence. Each scale measures the extent of the disturbed behaviour reported by staff, which is obviously dependent on the level of contact with the resident and the interpretation placed upon such behaviour. Thus, for example, it

is probable that some individuals described as unable to communicate were deaf rather than confused. In addition whether or not a certain behaviour was defined as unco-operative or restless often depended on the norms prevailing in any particular institutional environment. Nevertheless, the results for individual items do indicate the extent to which staff in homes perceive particular types of behaviour as presenting problems.

Throughout the Board's homes 15% of residents were described as having short and long-term memory loss. The lowest proportion was found in Omagh, 10% and the highest in Fermanagh, 17%, but none of the districts in the Western Board compared with the 30% found in East Belfast and Castlereagh. Londonderry, Limavady and Strabane District had the highest proportion who were completely disorientated, 18%, which was considerably in excess of the other districts but not as high as East Belfast and Castlereagh. The proportions relating to communication ability follow a similar pattern with 3% of residents in Londonderry, Limavady and Strabane District having no effective contact and 1% in each of the other districts. The proportion of residents in each district described as constantly restless was very small with the Western Board having 1% and East Belfast and Castlereagh 2%, a similar pattern was evident in relation to co-operation.

Table 11: Residents by Physical Care Items and District

Physical Care Items	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Mobility										
Fully ambulant including stairs	103	35	9	10	62	47	174	34	96	40
Usually independent	77	26	24	27	20	15	121	23	47	20
Walks with supervision	27	9	5	6	10	8	42	8	2	1
Walks with aids or under careful supervision	70	24	39	44	30	23	139	27	75	32
Bedfast or chairfast	20	7	11	13	10	8	41	8	18	8
Dressing										
Correct	116	39	22	25	47	36	185	36	92	39
Imperfect but adequate	77	26	30	34	33	25	140	27	36	15
Adequate with minimum of supervision	38	13	9	10	28	21	75	15	24	10
Inadequate unless continually supervised	35	12	14	16	13	10	32	6	52	22
Unable to dress or to retain clothing	31	10	13	15	11	8	55	11	34	14
Feeding										
Correct unaided at appropriate times	205	69	37	42	108	82	350	68	150	63
Adequate with minimum supervision	68	23	25	28	19	14	112	22	68	29

Table 11: Cont'd

Physical Care Items	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Feeding Cont'd										
Inadequate unless continually supervised	20	7	19	22	3	2	42	8	12	5
Usually independent	4	1	7	8	2	2	13	3	8	3
Bathing										
Washes and bathes without assistance	20	7	5	6	11	8	36	7	16	7
Minimal supervision with bathing	76	26	10	11	34	26	120	23	34	14
Close supervision with bathing	67	23	19	22	20	15	106	21	22	9
Inadequate unless continually supervised	35	12	3	3	5	4	43	8	21	9
Requires bathing	99	33	51	58	62	47	212	41	145	61
Continence										
Full control	178	60	20	23	86	65	284	55	128	54
Occasional accidents	67	23	43	49	34	26	144	28	57	24
Continent by day only if regularly toileted	22	7	5	6	7	5	34	7	20	8
Urinary incontinence in spite of regular toileting	26	9	17	19	3	2	46	9	20	8
Regular or frequent double incontinence	4	1	3	3	2	2	9	2	13	5

Mental Disturbance Items	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Memory										
Complete	128	43	19	22	63	48	210	41	53	22
Occasionally forgetful	85	29	54	61	43	33	182	35	83	35
Short-term loss	38	13	6	7	3	2	47	9	30	13
Short and long-term loss	46	15	9	10	23	17	78	15	72	30
Orientation										
Complete	144	48	20	23	81	61	245	47	78	33
Orientated in home identifies people correctly	66	22	56	64	25	19	147	28	71	30
Misidentifies but can find way about	34	11	3	3	15	11	52	10	34	14
Cannot find way to bed or toilet without assistance	29	10	6	7	4	3	39	8	32	13
Completely lost	24	8	3	3	7	5	34	7	23	10
Communication										
Always clear, retains information	119	40	23	26	73	55	215	42	66	28
Can indicate needs, understands simple verbal directions, can deal with simple information.	140	47	61	69	50	38	251	49	119	50
Cannot understand simple verbal information or cannot indicate needs.	13	4	0	-	1	1	14	3	12	5

Table 12: Cont'd

Mental Disturbance Items	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Communication Cont'd										
Cannot understand simple verbal information and cannot indicate needs, retains some expressive ability	16	5	3	3	7	5	26	5	31	13
No Effective contact	9	3	1	1	1	1	11	2	10	4
Restlessness										
None	169	57	19	22	94	71	282	55	136	57
Intermittent	101	34	61	69	35	27	197	38	85	36
Persistent by day or night	10	3	7	8	2	2	19	4	7	3
Persistent by day AND night	11	4	0	-	1	1	12	2	6	3
Constant	6	2	1	1	0	-	7	1	4	2
Co-operation										
Actively co-operative	115	39	28	32	98	74	241	47	109	46
Passively co-operative or occasionally unco-operative	115	39	28	32	21	16	164	32	89	37
Requires frequent encouragement or persuasion	54	18	25	28	12	9	91	18	31	13
Rejects assistance, shows independent ill-directed activity	6	2	6	7	1	1	13	3	5	2
Completely resistive or withdrawn	7	2	1	1	0	-	8	2	4	2

Table 13 shows the Total Behaviour Rating for residents in the different districts. The pattern was more or less what would be expected in the light of the preceding discussion on individual items. Just over half (52%) of the residents in homes in Londonderry, Limavady and Strabane District presented none or only slight behavioural problems (scores 0-9) compared with 20% in Omagh and 66% in Fermanagh. The corresponding figure for East Belfast and Castlereagh was 37%. At the other end of the scale only 2% of residents in homes in Londonderry, Limavady and Strabane District scored between 30 and 38 and in the other districts only 1% of residents were rated this high.

Table 13: Residents by Total Behaviour Rating and District

Total Behaviour Rating	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
0	10	3	1	1	7	5	18	3	4	2
1-9	145	49	17	19	80	61	242	47	83	35
10-19	103	35	53	60	35	27	191	37	107	45
20-29	34	11	16	18	9	7	59	11	39	16
30-38	5	2	1	1	1	1	7	1	5	2
TOTALS	297	100	88	100	132	100	517	100	238	100

The pattern of Total Behaviour Rating Scales is reflected in the mean scores of residents in the districts as shown in Table 14.

This suggests that residents in Omagh were collectively more dependent than those in the other districts in the Western Board and even more than the East Belfast and Castlereagh District despite the fact that the residents in East Belfast and Castlereagh are "older".

Table 14: Comparison of District by Behaviour Rating Scale Scores

	District				
Behaviour Rating Scale Scores	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	East Belfast and Castlereagh
Total number of Residents	297	88	132	517	238
Means BRSS	10.6	14.1	8.8	10.7	12.8
% scoring less than 10	52.2	20.4	65.9	50.2	36.5
% Scoring 20 or more	13.1	19.3	7.6	12.8	14.7

Tables 15 and 16 show the ratings for the physical dependency and mental disturbance items analysed separately. A degree of mental infirmity often results in physical dependence (eg confused old people are usually unable to dress themselves) but physical infirmity does not result in mental disturbance. Thus it was not surprising that fewer people were found to be mentally disturbed than were found to be physically dependent. One per cent of all the residents in the Western Board scored 16-19 on the mental disturbance scale as opposed to 4% scoring 16-19 on the physical dependency rating.

Table 15: Residents by Total Physical Dependency Rating and District

Total Physical Dependency Rating	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
0	18	6	4	5	10	8	32	6	12	5
1-5	128	43	12	14	53	40	193	37	80	34
6-10	95	32	45	51	50	38	190	37	82	34
11-15	47	16	18	20	17	13	82	16	51	21
16-19	9	3	9	10	2	2	20	4	13	5
TOTALS	297	100	88	100	132	100	517	100	238	100

Table 16: Residents by Total Mental Disturbance Rating and District

Total Mental Disturbance Rating	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
0	54	18	3	3	51	39	108	21	32	13
1-5	143	48	44	50	54	41	241	47	106	45
6-10	69	23	38	43	17	13	124	24	65	27
11-15	27	9	2	2	9	7	38	7	33	14
16-19	4	1	1	1	1	1	6	1	2	1
TOTALS	297	100	88	100	132	100	517	100	238	100

Appropriateness of Placement

Persons completing the questionnaires were asked to give their opinion as to whether the particular resident was in the best place in the light of his physical and mental condition. Analysis of the replies to this question is shown in Table 17. Among the 517 persons surveyed 80% were considered to be appropriately placed but 99 residents (19%) were considered to be inappropiately placed. Respondents from all districts reported some residents to be inappropriately placed but there was considerable variations between districts ranging from 9% in Omagh to 36% in Fermanagh. The corresponding figure for East Belfast and Castlereagh was 12%. See Table 17.

Table 17: Residents by Appropriateness of Placement and District

Appropriateness of Placement	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Yes	252	85	80	91	84	64	416	80	205	86
No	44	15	8	9	47	36	99	19	28	12
Don't Know	1	1	0	-	1	1	2	-	5	2
TOTALS	297	100	88	100	132	100	517	100	238	100

Table 18 shows the type of placement applicable to those 416 elderly people who were considered to be appropriately placed. All districts show a similar pattern with virtually all residents in homes on the census date being there on a permanent basis.

Table 18: Residents by Type of Placement and District

Type of Placement	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Permanent	251	100	80	100	82	98	413	99	201	98
Holiday Relief	1	-	0	-	1	1	2	-	-	-
Home Crisis	0	-	0	-	0	-	0	-	2	1
Other	0	-	0	-	1	1	1	-	-	-
Dont'Know	0	-	0	-	0	-	0	-	2	1
TOTALS	252	100	80	100	84	100	416	100	205	100

For those 99 residents who were considered inappropriately placed Table 19 shows the type of accommodation considered by the person completing the questionnaire to be most suitable. For 28 people (28%) sheltered housing was considered to be the most suitable alternative while for a further 24 residents (24%) a specialist home for the elderly mentally infirm was considered most appropriate. 13 people were considered suitable for living at home without a resident warden and a further 20 were thought to need some form of hospital provision.

Table 19: Residents by most appropriate Accommodation and District

Most Appropriate Accommodation	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Own Home	9	20	0	-	4	9	13	13	1	4
Sheltered Housing	9	20	3	38	16	34	28	28	3	11
Old People's Home	3	7	1	13	0	-	4	4	0	-
EMI Home	9	20	1	13	14	30	24	24	1	4
Nursing Home	1	2	0	-	5	11	6	6	0	-
Geriatric Ward	4	9	1	13	5	11	10	10	11	39
Psychiatric Ward	2	5	2	25	2	4	6	6	4	14
Psychogeriatric Ward	3	7	0	-	0	-	3	3	5	18
Other Hospital Ward	1	2	0	-	0	-	1	1	1	4
Other	3	7	0	-	1	2	4	4	2	7
Not Known	0	-	0	-	0	-	0	-	0	-
TOTALS	44	100	8	100	47	100	99	100	28	100

Although 99 people were considered to be inappropriately placed such assessments are not always matched by action to resolve misplacement. Staff were therefore asked to supply information about whether alternatives were being sought and, if so, when applications were made or first made, if there had been more than one application. The replies to these questions are shown in Tables 20 and 21. Overall, in only one out of 5 cases in which misplacement was identified was action being taken to seek an alternative. Among the 20 for whom application for alternative placement had been made 3 had been made less than one month from the census date and 5 had been made more than 12 months earlier.

Table 20: Residents by Accommodation being sought and District

Accommodation being sought	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Yes	10	23	4	50	6	13	20	20	12	43
No	33	75	4	50	41	87	78	79	16	57
Don't Know	1	2	0	-	0	-	1	1	0	-
TOTALS	44	100	8	100	47	100	99	100	28	100

Table 21: Length of Time since Application by District

Length of Time since Application	District									
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board		East Belfast and Castlereagh	
	No	%	No	%	No	%	No	%	No	%
Under 1 Month	1	10	1	25	1	17	3	15	2	17
1-5 Months	5	50	2	50	3	50	10	50	4	33
6-11 Months	1	10	0	-	0	-	1	5	2	17
12 Months or More	2	20	1	25	2	33	5	25	4	33
Not Known	1	10	0	-	0	-	1	5	0	-
TOTALS	10	100	4	100	6	100	20	100	12	100

Table 22: Services required at Home by District

Services Required	District				
	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	East Belfast and Castlereagh
Attendance at Day Hospital	-	-	1	1	
Attendance at Day Centre	6	3	14	23	
Day Care in OPH	-	-	5	5	
Attendance at Social Club	5	2	12	19	
Short stays in OPH	-	-	1	1	2
Home Help Service	8	3	15	26	
Night Sitter Service	-	-	5	5	1
Meals-on-Wheels	5	3	15	23	1
Laundry Service	4	1	12	17	
Visits from District Nurse	3	-	3	6	2
Visits from Health Visitor	1	-	6	7	2
Visits from Social Worker/ Social Work Assistant	6	3	19	28	3
Bath Attendant	1	1	7	9	1
Chiropody	1	2	14	17	
Neighbourhood Warden	2	-	8	10	
Other	-	-	6	6	
N=	18	3	20	41	4

In addition to identifying those residents who were considered to be inappropriately placed respondents were asked to indicate if residents had been involved in any discussion of the alternative placements being suggested in the questionnaire. The replies to this question are shown in Table 23. Out of the 99 people identified as misplaced almost half, 42 residents, had been involved in some discussion about alternatives.

Table 23: Residents by Discussion of Alternatives and District

	District							
Discussion of Alternatives	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board	
	No	%	No	%	No	%	No	%
Yes	14	33	6	75	22	47	42	43
No	29	67	2	25	25	53	56	57
TOTALS	43	100	8	100	47	100	98	100

Discussion of alternatives, however, does not imply agreement and as can be seen from Table 24 some 15 residents did not agree with the alternatives being proposed. Despite this the fact remains that 25 residents had discussed alternative placements and were in agreement with the suggestions made.

Table 24: Residents by Agreement on Alternatives and District

Agreement on Alternatives	District							
	Londonderry, Limavady and Strabane		Omagh		Fermanagh		Western Board	
	No	%	No	%	No	%	No	%
Yes	11	79	5	83	9	41	25	60
No	1	7	1	17	13	59	15	36
Not Known	2	14					2	5
TOTALS	14	100	6	100	22	100	42	100

2. ADMISSIONS

In this section information on people admitted permanently to old people's homes in the 3 districts of the Western Health and Social Services Board during the period 1 July to 31 December 1982 is presented. In addition to information on the basic characteristics such as age, marital status, physical and mental state and on the type and level of services being provided by the Board at the time of admission an attempt will be made to isolate and identify the main reasons for admissions.

During the 6 months from 1 July to 31 December 1982 there were a total of 98 admissions to old people's homes in the 3 districts. There were 59 admissions on a permanent basis and 29 temporary admissions for holiday relief or periods of home crisis such as the illness of a caring relative. The information in this paper relates only to 51 of the 59 people admitted on a permanent basis. The 51 people were distributed among the 3 districts as follows:

- Londonderry, Limavady and Strabane - 29
- Omagh - 10
- Fermanagh - 12

Age

As early as 1962 Townsend(3) found proportionately more new residents from the older age groups than would have been expected from the general population of over 65 years. This tendency has since been confirmed by subsequent studies of new admissions(4,5)

and is clearly related to the higher levels of physical and mental dependency among the older groups. Among the total elderly population (age 65 years and over) in the Western Board's area, 64.3% were aged betwen 65 and 74 years, 29.4% were aged between 75 and 84 years and 6.3% were aged 85 years and over. Among those admitted to residential homes, 31% were in the youngest age group, 49% in the middle age group and 16% in the oldest age group. Thus the pattern found in the earlier studies has been confirmed. Table 25 shows the distribution of people admitted by age and district and these may be compared with figures from an earlier Northern Ireland study(6) which showed that among a sample of 143 admissions to old people's homes, 14% were aged between 65 and 74, 53% were aged between 75 and 84 years and 29% were aged 85 years and over.

Table 25: Residents by Age and District

	District				
Age	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Under 65	1	1	-	2	4
65-74	9	4	3	16	31
75-84	15	4	6	25	49
85+	4	1	3	8	16
TOTALS	29	10	12	51	100

Marital Status

Studies over the past 20 years(7, 8 and 9) have consistently shown that people admitted to residential care are much more likely than those remaining in the community to be single and to a lesser extent, to be widowed, divorced or separated. Those who have never been married were over-represented in Townsend's sample, and, similarly Kay, Beamish and Roth found the proportion of single people in their sample of first admissions to welfare homes was 3½ times higher than in the general population of elderly, but for married people the proportion was only 1:20.

The higher than expected proportion of widowed people entering institutional care is undoubtedly associated with age at admission. However, the very large numbers of those who have never been married is probably more related to the absence of spouses and family as potential sources of support.

The small numbers of married people entering homes not only reflect the support a spouse can provide but also the lack of facilities which would enable a couple to maintain the privacy of married life. Studies show fairly close agreement in the proportion of admissions who are married. Around 6% of new admissions are married, although it is frequently only the more disabled partner who is admitted, and separation of the couple is therefore common.

Among the total elderly population in the Board's area, 25% were single, 32% widowed and 43% married. Table 26 shows the

marital status of those admitted to homes for the elderly - 41% were single, 39% were widowed and 18% were married. Thus we find that single and widowed were over-represented in this sample of admissions and the 18% who were married, whilst under-representing the elderly population who were married throughout the Board's area, formed a more significant group than revealed in earlier national studies. The corresponding figures from the other Northern Ireland study are single - 21%, widowed - 69% and married - 9% revealing a considerably different pattern between 2 areas of the province.

Table 26: Residents by Marital Status and District

	District				
Marital Status	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Single	10	6	5	21	41
Married	5	1	3	9	18
Widowed	13	3	4	20	39
Separated/Divorced	1	-	-	1	.2
TOTALS	29	10	12	51	100

Sex

The national studies quoted earlier suggest that the pre-dominance of women among the very elderly is reflected among

those in residential care. However, relative to the numbers of men and women in the general population over 65, proportionately more men were admitted than would be expected particularly from the younger age ranges.

Various studies(3, 10) have commented on this finding and from impressionistic interview data have suggested that, upon the loss of a spouse, this generation of men are unable or unwilling to undertake the daily household tasks that have traditionally been the woman's role.

Among the total elderly population in the Board's area, 45% were male and 55% female. Among those admitted to homes, 43% were male and 57% female (see Table 27) which corresponds closely with the proportions in the total population. However, comparision with the other local study reveals marked differences. Among the admissions in that study only 17% were male and the remaining 83% female.

Table 27: Residents by Sex and District

	District				
Sex	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Male	12	5	5	22	43
Female	17	5	7	29	57
TOTALS	29	10	12	51	100

Place from which Admitted

Table 28 shows the place from which people were admitted to the homes. Throughout the Board's area some 66% were admitted from their own homes or the home of a relative with whom they had been living. Almost one-quarter were admitted from some form of hospital care. These figures are considerably different from those in the other local study which revealed that 74% of admissions came from their own home and 20% from a hospital setting. However, one needs to bear in mind that 50% of this sample were admitted for temporary reasons.

Table 28: Residents by Place from which Admitted and District

	District				
Place from which Admitted	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Own Home (not sheltered dwelling)	20	5	9	34	66
Own Home (sheltered housing)	-	-	-	-	-
Old People's Home (Board)	-	-	1	1	2
Old People's Home (Vol/Private)	2	-	-	2	4
Home for Elderly Mentally Infirm	-	-	-	-	-
Geriatric Ward	3	1	-	4	8
Psychogeriatric Ward	-	-	-	-	-
Other Hospital Ward	3	4	1	8	16
Nursing Home	-	-	-	-	-
Other	1	-	1	2	4
TOTALS	29	10	12	51	100

Method of Admission

Table 29 shows that the vast majority of people (73%) were admitted routinely from the waiting list and the remainder either on an urgent basis or in an emergency.

Table 29: Method of Admission by District

	District				
Method of Admission	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Routinely from Waiting List	16	3	6	25	73
Urgently from Waiting List	1	1	1	3	9
Emergency	3	1	2	6	18
TOTALS	20	5	9	34	100

Availability of Accommodation

Out of the 51 people admitted to homes 15 were in hospital at the time of admission. Four people out of this group of 15 had accommodation in the community to which they might have returned, 3 people had no accommodation because their former homes were let, sold or unsuitable and a further 4 people had no accommodation as they previously lived with a family who did not want the person back. See Table 30.

Table 30: Availability of Accommodation for those Admitted from Hospitals and Voluntary Homes

Availability of Accommodation	District				
	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Yes	1	3	-	4	27
No - previously lived in rented accommodation now let	1	-	-	1	6
No - previously lived in lodgings now unavailable	-	-	-	-	-
No - previously lived in own house - now sold/ unsuitable	2	-	-	2	13
No - previously lived with family - did not want person back	2	2	-	4	27
No - other reason	3	-	1	4	27
TOTALS	9	5	1	15	100

Living Arrangements Prior to Admission

In Table 31 information about the living arrangements prior to admission are presented for the 34 people who were living in the community at the time of admission. Just over a half (53%) of residents lived alone at the time of admission and almost one-third (29%) lived with children. In the other local study, 37% lived alone and 36% lived with children. However, the data is not strictly comparable as the information in the latter study reflects the situation which pertained even if the person had been admitted from another home or hospital and the sample, as mentioned earlier, included those who had been admitted for temporary periods such as holiday relief.

Table 31: Living Arrangements by District

	District				
Living Arrangements	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Alone	10	4	4	18	53
With spouse only	1	-	-	1	3
With spouse and children	2	-	-	2	6
With children	4	1	3	8	23
With brothers and sisters	3	-	-	3	9
With other relations	-	-	1	1	3
With others	-	-	1	1	3
TOTALS	20	5	9	34	100

Length of Time Since Application

Information was obtained about the date on which application was made for admission to residential care and this was related to the date on which the person was admitted to the home. The results of this are presented in Table 32. For 6 people (11%) the forms were completed at the time of application. For the remaining 45 people, 11 (22%) were placed less than one month after application, 18 (36%) between one and 5 months and 13 (26%) between 6 and 11 months. Two people had to wait for more than 12 months. The corresponding figures for the other local survey are 16%, 26%, 45% and 11%.

Table 32: Length of Time on Waiting List by District

	District				
Length of Time	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Never	1	2	3	6	11
Less than 1 month	4	4	3	11	22
1-5 months	12	1	5	18	36
6-11 months	9	3	1	13	26
12 months or more	2	-	-	2	4
Not Known	1	-	-	1	2
TOTALS	29	10	12	51	100

Preference

Almost half the residents had stated a preference for a particular home. This was most pronounced in the Londonderry, Limavady and Strabane District and may be due in part to the larger size of the district and the location of homes throughout the district. See Table 33.

Table 33: Preference Stated by District

	District				
Preference Stated	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Yes	16	3	5	24	47
No	11	7	7	25	49
Do not Know	2	-	-	2	4
TOTALS	29	10	12	51	100

Person Initiating Application

In only just over one-third of cases was the application initiated by the elderly person. General practitioners initiated 11% of admissions and relatives and hospital staff accounted for a further 44%, split equally between them. See Table 34.

Table 34: Person Initiating Application by District

Person Initiating Application	District				
	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
The Applicant	9	5	4	18	35
Relatives	5	3	3	11	22
Social Worker	1	-	-	1	2
Social Work Assistant					
Health Visitor					
District Nurse					
General Practitioner	2	1	3	6	11
Hospital Staff	9	1	1	11	22
Others	3	-	1	4	8
TOTALS	29	10	12	51	100

Health Characteristics

Information on health characteristics was available from the medical certificates completed on each resident by their GP or, for those in hospital at the time of admission, by the hospital doctor. Certificates were available for 48 residents and the information from these is presented in Tables 35 to 40.

Mobility

Among the 48 residents, 18 (38%) were described as fully mobile and 20 (41%) were described as requiring supervision or aids and one person was described as chairfast. See Table 35.

Table 35: Mobility of Residents by District

	District				
Mobility	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Fully mobile	10	2	6	18	38
Can walk unaided, unable to climb stairs	5	2	2	9	19
Requires supervision	4	1	-	5	10
Walking aids required	10	3	2	15	31
Chairfast	-	1	-	1	2
Bedfast	-	-	-	-	-
TOTALS	29	9	10	48	100

Orientation

Just over two-thirds of the residents, 33 people, were described as completely orientated and only 2 people (4%) were considered fully disorientated. See Table 36.

Table 36: Orientation of Residents by District

	District				
Orientation	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Complete	20	6	7	33	69
Slightly impaired	6	2	2	10	21
Aware of surroundings, misidentifies persons	1	1	1	3	6
Fully disorientated	2	-	-	2	4
TOTALS	29	9	10	48	100

Communication

Nearly all the residents had no problems with communication and only one person was described as "unable to communicate". See Table 37.

Table 37: Communication of Residents by District

Communication	District				
	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Memory good	13	6	7	26	54
Understands simple information and verbal instructions	14	2	3	19	40
Able to indicate needs	1	1	-	2	4
Expressive ability	-	-	-	-	-
Unable to communicate	1	-	-	1	2
TOTALS	29	9	10	48	100

Restlessness

Just over one-third of residents were described as having problems in this area. 13 people (27%) were described as being intermittently restless, 2 (4%) as being nocturnally restless and 3 (6%) as being restless by day and night. See Table 38.

Table 38: Restlessness of Residents by District

	District				
Restlessness	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
None	17	7	6	30	63
Intermittent	8	2	3	13	27
Nocturnal Restlessness	1	-	1	2	4
Restlessness - day and night	3	-	-	3	6
TOTALS	29	9	10	48	100

Vision

Among the 48 residents 29 (61%) were described as having good vision and only 4 (8%) as having poor vision. See Table 39.

Table 39: Vision of Residents by District

	District				
Vision	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Good	18	5	6	29	61
Fair	10	2	3	15	31
Poor	1	2	1	4	8
None	-	-	-	-	-
TOTALS	29	9	10	48	100

Hearing

The majority of residents - 30 people (63%) were described as having good hearing and only 4 people (8%) were described as having poor or no hearing. See Table 40.

Table 40: Hearing of Residents by District

	District				
Hearing	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Good	19	5	6	30	63
Fair	9	2	3	14	29
Poor	-	2	1	3	6
None	1	-	-	1	2
TOTALS	29	9	10	48	100

Services provided at the time of Admission

Very few studies have compared old people admitted to residential homes with those remaining in their own homes in terms of levels of provision of domiciliary services. In spite of this, an emphasis on the extension of community care and the limitation of residential care underlies much of the current discussion on future policies for the care of the elderly(11). In England, data on the levels of mental and physical dependency amongst residents of local authority homes(12) tends to challenge the view that domiciliary services could adequately cater for substantial numbers of very disabled people currently in residential care. In Northern Ireland, however, 2 studies(13,14) suggest that there may be a considerable number of elderly people in residential care who with adequate housing and support services could have been maintained in the community for much longer than they have been.

The data available suggest that contact with the statutory social services is such a rare event for most elderly people(15) that its importance as a factor either in precipitating or preventing admission to residential care cannot be assessed at this time.

Townsend(16) found that only 19% of those admitted to residential homes from a private household had previously received any statutory domiciliary services and only 1% had depended upon an outside service for most of their mid-day meals. These findings tend to confirm those in an American study(17) which concluded

that domiciliary services are only infrequently an option in weathering the crisis that often precipitates an admission and that prior to that crisis little preventive work is done by statutory services.

By way of limited comparision the local study referred to earlier revealed that 50% of those admitted permanently to an old people's home were receiving the home help service, 2 out of the 34 were receiving a night sitter service, 7 people (21%) were in receipt of meals-on-wheels, 3 people (9%) attended the day centre, 5 people (15%) were visited by a neighbourhood warden, one person attended a day hospital and 9 people (26%) were being visited by a district nurse.

It is against this background that the provision of services at the time of admission to homes in this area needs to be viewed. Among the 34 people living in the community, 15 people (44%) were in receipt of the home help service, 4 people (12%) attended a day centre, 2 people (6%) received day care at an old people's home and 2 people (6%) attended a day hospital and finally one person received visits from a district nurse. See Table 41.

Table 41: Services being received by Residents Prior to Admission by District

Services	District			
	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board
				No
Home Help Service	7	3	5	15
Meals-on-Wheels	-	-	-	-
Day Centre	1	-	3	4
Day Care at OPH	1	1	-	2
Luncheon Club, Social Centre or Craft Class	1	-	1	2
Neighbourhood Warden	-	-	-	-
Short Stays in OPH	1	-	3	4
Day Hospital	1	-	1	2
District Nurse	-	-	1	1

Reasons for Admission

From an examination of the information contained in the various forms completed for residential accommodation and the content of the social report completed by the social services staff the researcher attempted to ascertain the main reason for admission to the homes. The classification used was as follows:-

Environmental - eg living accommodation unsuitable or no accommodation available either because of its location, amenities in the home or size of home or other reason.

Personal - needed closer surveillance than was/would have been available, eg because of tendency to fall, forget medication, does not eat, safety hazard, or other reason.

Family Crisis - the supporting family were/would have been under undue stress either physical, emotional or financial or were no longer able or willing to care or support the elderly person.

Other -

The results of this are shown in Table 18 which reveals that the main reason for admission for 6 residents (12%) was environmental, for 25 residents (49%) personal, for 18 residents (35%) family crisis and 2 residents (4%) other reasons. The corresponding figures from the earlier local study for 34 residents admitted to homes on a permanent basis were - 6%, 53%, 26%, and 15%. See Table 42.

Table 42: Main Reason for Admission by District

Main Reason	District				
	Londonderry, Limavady and Strabane	Omagh	Fermanagh	Western Board	
				No	%
Environmental	2	2	2	6	12
Personal	17	5	3	25	49
Family Crisis	10	2	6	18	35
Other	-	1	1	2	4
TOTALS	29	10	12	51	100

3. POLICIES, PROCEDURES AND DECISION-MAKING

The Allocation of Places

In Londonderry, Limavady and Strabane District there was no allocation or admission panel. Allocations to homes were undertaken by the principal social worker (residential and day care services) and 2 senior social workers. Each senior social worker had responsibility for 4 homes in the district. The basic procedure for admission was that when a vacancy occurred in a home the waiting list was examined by the senior social worker. This list was maintained in 2 parts - one dealing with urgent cases and the second containing "normal" applications. When an applicant was identified as suitable for the vacancy which had arisen, the senior social worker notified the social worker who had been dealing with the application that a bed was available and asked them to contact the applicant to see if he/she wished to proceed to admission to the home. At the same time the officer-in-charge of the home was notified about the proposed admission and arranged to visit the elderly person at home or in hospital. Arrangements would be made, where possible, for the elderly person to visit the home prior to admission.

In Omagh District there was an admission panel which consisted of the 2 officers-in-charge of the homes in the district, the senior social worker of the elderly care team, the assistant principal social worker (residential and day care services). The district social services officer attended occasionally but no other

disciplines attend. Meetings were held every 4-6 weeks and alternated between the 2 homes with 3-4 weeks' notice being given. The basic procedure for dealing with applications was that the social worker or social work assistant presented a completed application form which would have been discussd with the team leader. The general rule was that applications from people resident in the community were dealt with by a social work assistant in the elderly care team, the social workers in the team for the handicapped and social workers for those who were resident in hospital at the time of application.

The functions of the panel were to deal with all new referrals for admission to residential homes and to deal with those cases already on the waiting list for admission. In addition the panel also reviewed those people who have been admitted at the last admission meeting. The officers-in-charge completed a form for the information of the panel which highlighted the difficulties which they were experiencing with residents. The panel also discussed policy issues which were under active discussion either in the district or the Board generally. Examples of this were the provision of beds for rehabilitation or beds for holidays. An attempt was made to achieve a consensus at the panel meeting but ultimately the final decision rested with the assistant principal social worker (residential and day care services).

In Fermanagh District the admission panel consisted of the assistant principal social worker (residential and day care services), the team leader of the elderly care team and the 2

social workers from that team. The assistant principal social worker (fieldwork services) was also invited but was not a regular member of the team. The officer-in-charge where the vacancy arose also attended by invitation. No other disciplines attended but could have been consulted by telephone. Meetings were not held on a regular basis and were only convened as a vacancy arose which on average was once in every 3 months.

The basic procedure for dealing with applications was that prior to a meeting the assistant principal social worker held a discussion with the team leader to select 4-6 applicants from the waiting list for consideration by the panel. Application forms were submitted to the assistant principal social worker before the meeting. The assistant principal social worker chaired the meeting and considered all cases. The social workers introduced the cases and supplemented the information contained in the application forms.

The function of the panel was to allocate places on a priority basis. However this panel now prescribes the programme of care for each resident which is to be discussed with senior home staff. Efforts were made to achieve a consensus at panel meetings but ultimately the decision rested with the assistant principal social worker (residential and day care services) although she indicated that the need for a unilateral decision seldom arose.

The Health and Personal Social Services (Northern Ireland) Order 1972

The managers were asked if the Health and Personal Social Services (Northern Ireland) Order helped them in their decision-making. The general response was that the managers were fully aware of the wording of the Order but that it was of little value in the normal decision-making of the panel. One respondent did mention that Section 37 of the Order dealing with compulsorily removal from home had potential for use although it had not yet been used.

Department of Health and Social Services (Northern Ireland) Circulars

Enquiries were made about the influence of the Departmental Circulars/Guidance on the decision-making process. In Londonderry, Limavady and Strabane District the manager there said that the DHSS(NI) circular arrangements for health care was useful in considering eligibility but suggested that something more definitive would be useful. In Omagh the manager acknowledged the existence of this circular and another entitled "Assessment of Ability to Pay for Residential Accommodation" but stated that they were not referred to by the admission panel. In Fermanagh the manager said that these circulars were used in discussions on admissions but she was unable to be more specific about this.

Western Health and Social Services Board Guidance

When asked about guidance issued by the Board each manager referred to a number of papers as influencing their practice. In Londonderry, Limavady and Strabane District the manager referred to papers issued by the Board setting out:

(a) criteria for admission to residential care;
(b) the philosophy of residential care for the elderly and
(c) policy statement issued by the Director of Social Services.

The papers at (a) and (b) are attached as Annexes J and K respectively. The last document was in draft form only and was considered too confidential to release to the researcher. In Omagh District the only Board guidance referred to was the policy statement issued by the Director of Social Services, and in Fermanagh District reference was made to the paper on philosophy at(b) above and the policy paper issued by the Director of Social Services.

The Presence of a Carer

The managers were asked if the presence of a carer had any effect on the decision-making regarding the allocation of a place. All agreed that the presence of a person caring for an elderly person was taken into account but this did not automatically mean that the application received a lower priority. It was suggested that the total domestic situation was taken into account. Factors

mentioned in this context were the working pattern of the carer; how well the carer could carry out the task; stress on the carer - possible threat to prospective resident (in one district the manager suggested that in some cases priority may be higher because of the danger of physical abuse to an applicant by the carer).

Consideration of Alternatives

In the 2 districts in which there were panels operating the managers said that alternatives to residential care were considered by the panels. It is not automatically assumed that all alternatives have been sufficiently explored by the social worker/social work assistant submitting the application. In one district there is a full discussion of alternatives by the panel and in some cases applications are referred back for a full assessment and an exploration of other possibilities. In the remaining district the consideration of alternatives is seen as the responsibility of the social worker dealing with the application before the papers are forwarded to the residential and day care section.

In all 3 districts the managers indicated that the alternatives considered were likely to be a range of existing domiciliary and/or day care services eg home help service, meals-on-wheels, day care in a day centre or an old people's home.

Balance in the Home

The managers were asked if, in allocating places in homes, they attempted to achieve social balance in terms of age, background, ability etc. Two managers indicated that they made no attempt to achieve a social balance. The third manager suggested that she had no opportunity to do so and that more emphasis was placed on the wishes of the applicant. In the large district the manager there said that homes were scattered throughout the district and residents would reflect the demographic pattern of the part of the district in which the home was located.

Waiting Lists

A waiting list operated in all 3 districts. In one district the list, on which there are 47 names, was maintained in 2 parts, (a) - urgent and (b) - normal. The places were normally dealt with on a chronological basis but length of wait did not automatically give priority for a place. Urgent cases were given first priority when a vacancy arose. In another district the waiting list was divided into 2 sections(1) - an active list on which names of serious contenders for residential care were contained. In these cases the decision had been made that it was the only solution to the individual's problem;(2) - an inactive list which contained names of people who had requested admission to residential care at some stage in the future. These requests for admission were not discussed at the regular meeting of the panel and were considered to be there for "insurance" purposes only.

There were 5 people on the active waiting list and 13 on the inactive waiting list. No priority was given to those who had been on the waiting list for a long time. In the third district there were 25 people on the waiting list for admission to residential homes. The manager felt that they were all genuine applications although she considered that some were making plans for the longer term future. The length of wait did not give any priority as there were a limited number of vacancies and the circumstances of applicants were therefore more important.

The Applicants's Wishes

All the managers agreed that whenever possible the applicant's wishes were taken into account at the time of allocation of places. However, in one district the manager indicated that this was not possible in relation to 2 of the 8 homes in the district as these homes could not cope with the demand from the whole catchment area and some applicants had to be directed to those homes. In another district there appeared to be no pattern of stating a preference for a particular home.

Emergency Admissions

The managers were asked to outline the factors which resulted in the decision to admit an elderly person to residential care as an "emergency". Among all the admissions in the 3 districts in the last 6 months only one admission could be defined as such. In one district an emergency was described as an elderly person

becoming homeless or "at risk" or the immediate carer being admitted to hospital; in another, emergency was defined as an elderly person who has been rendered homeless or was unable to manage even with the support from health and social services which would normally be available; and in the third district an emergency was defined as an applicant who is gravely at risk either physically or emotionally.

Swop Systems

The managers were asked if they operated a swop system with the local general hospital or geriatric unit. In 2 districts the managers were emphatic that they had no swop system in operation but in the third the manager indicated that she would operate such a system if the person in hospital met the criteria for admission to residential care. The district also had a policy of maintaining a place in the home for a period of 4 weeks when a resident was admitted to hospital. These swop arrangements were long established but were used very infrequently.

Hospital/Community Ratios

The managers were asked if they had a set number of places allocated to people occupying hospital beds. All 3 managers indicated that they had no set number of places allocated to people in hospital. However, one manager indicated that an attempt was made to achieve a balance in the allocation of places and during the previous year approximately 50% of places were allocated to individuals in hospitals and 50% to those in other locations.

Financial Situation

The managers were asked if a person was considered ineligible for a Board home on the basis of capital and income, ie, it was considered he could afford private care. All managers agreed that a good financial situation did not bar an elderly person from applying and being considered for residential care. The assessment scheme prepared by the Department of Health and Social Services (Northern Ireland) was used to determine the charges for each individual resident. When the charge had been determined the person was advised and could decide to enter the home or not. In some cases an applicant was advised that a place in a voluntary home was cheaper if this was the case. The choice was left to the applicant and the Board supplemented in a voluntary home provided the applicant had met the criteria for admission laid down by the Board.

Medical Assessment

In all 3 districts people were usually medically assessed before entering medical care. The only exception was in the case of emergency admissions. The same assessment form was used in all 3 districts and sought information about mobility, orientation, communication, restlessness, vision, hearing, infectious diseases, continence, ability to live with a group, particulars of any medical/nursing treatment required and medication. The assessment was carried out by the general practitioner for those applicants who were resident in their own homes and by the consultant for those who were occupying hospital beds. In one district the assessment was carried out and the form completed at

the time of application. If the admission was delayed for more than one month the medical certificate would be updated and if the admission was delayed for 6 months or more a completely new assessment would be undertaken. A similar procedure applied in another district but in the third district the assessment was carried out after the decision to allocate a place had been made by the panel and before admission to the home.

Incontinence and Related Conditions

All 3 managers indicated that they had quite liberal approaches to incontinence. In one district the manager said that one would need to define incontinence. He suggested that one would wish to explore the reasons for the incontinence and to examine its management. He was of the opinion that incontinence as such would not be a bar to admissions to the homes but would only be a problem if it was found to be unmanageable within the staffing structure of the home. He said that it was more likely that they would not be able to accept those who were incontinent of faeces or doubly incontinent. He suggested people who were catheterized would not normally be admitted because of the risk of infection. In another district the manager there suggested that applicants would have to be doubly incontinent and the incontinence to be of a continous rather than occasional nature before it would jeopardise their chances of entering residential accommodation. She suggested that they would be concerned to ensure that all possible medical assessment and treatment was explored and made available for those people who were incontinent. In relation to those applicants who are catheterized and those who have colostomies, she said that they would be admitted on the under-

standing that the amount of care and help needed could be provided by the staff in the home and would not be in excess of that capable of being provided by a caring relative. The district nurse would be asked to visit the home to perform a range of duties in this connection.

Self Care Ability

Self care ability was defined to include getting in and out of bed, washing, dressing, feeding, using the toilet and being mobile. In one district the manager said that inability of an applicant to undertake the tasks listed did not automatically render him ineligible for admission to a home. He felt that the only reason a person could not be admitted would be if he was totally bedfast. A similar response was forthcoming from the other 2 districts which suggested that in most homes there would be some help available with all of these tasks and difficulties would only arise where a person was incapable of doing all of these tasks and this detracted from the time available for other residents.

Mental State

Only one district had a specialist home for the elderly mentally infirm. The criteria for admission to this home were (a) signs of confusion plus one or more of the following - wandering; inability to protect self from danger; disorientation of time, places, person; constant talking; interfering with other residents' belongings, and (b) deteriorated behaviour in dressing, washing, toileting and feeding and (c) pre-senile

dementia or behaviour that puts other residents at risk, eg disturbed behaviour with other related problems of confusion. The manager indicated that some elderly people who were confused were maintained in other old people's homes - the behaviour of residents determining the continuation of the placement. In the other districts the managers there suggested that mental infirmity in a resident would be acceptable in an ordinary residential home if the person did not wander continuously or was not aggressive.

The Definition of Risk

The idea of risk plays a large part in the allocation of residential care places and managers were asked to define "at risk". Generally all managers agreed that an applicant has a greater chance of becoming a resident if his needs were of a physical nature rather than related to social or emotional factors. However, all acknowledged that one needed to take account of the wider context to include the needs of supporters of elderly people as appropriate.

Rejection of Applications

Only one manager had any information on the number of applications rejected during the past 12 months. In one district the manager suggested that the number of people rejected for application would be difficult to quantify as some would have been screened out before a formal application had been made and therefore would not appear on the waiting list. However, he was of the opinion that very few applications were rejected.

In the one district in which there was information on rejections the manager there said that 4 people had been rejected in the previous 12 months. One was rejected on the grounds that he required a high degree of personal care which was not available in the homes in the district; one was a young chronic sick person who was not considered suitable for the environment provided by a residential home for the elderly; another applicant was a 60 year old man suffering from multiple sclerosis who required a high degree of personal care, and finally one lady in hospital who was very confused and could not be dealt with in an ordinary residential home.

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CHAPTER 8

A REVIEW OF THE CASE STUDIES

The aims of this chapter are to review to main findings of the case studies; to discuss the possible reasons for the pattern of service provision which has been observed and to consider the implications of the findings for the policy of community care for elderly people.

HOME HELP SERVICE

Recipients

The characteristics of elderly recipients of the home help service were examined in terms of

a. Household Characteristics

i. Composition. In eighty per cent of householders there was one elderly person and in the remainder, with one exception, there was only one other elderly person.

ii. Type. The vast majority lived in a whole house, with the remainder in flats, bedsitters or other arrangements.

iii. Ownership. Almost three quarters of the sample lived in publicly owned housing.

iv. Labour Saving Devices. While nearly all households had the use of a cooker only about one third had a refrigerator or washing machine. Just over half had a vacuum cleaner.

b. Personal Characteristics

i. Source of Referral. Just over half of all referrals were from elderly people themselves or their relatives. Referrals from primary and hospital health care teams accounted for less than one third of all referrals.

ii. Length of time in receipt of service. Only 7 per cent of the sample had been receiving the service for less than 6 months. Sixty per cent had been in receipt of the service for more than 2 years and 32 per cent for more than 5 years.

iii. Age. Just over 36 per cent of the recipients were in the age range 65 to 74 years, compared with 65 per cent in the total elderly population and 11 per cent of recipients were over 85 years of age compared with 6 per cent of the total elderly population. The age of recipients when compared with residents in homes in the same district shows that while 36 per cent of recipients were in the age range 65 to 74 years and 11 per cent of recipients were over 85 years the corresponding figures for residents were 22 per cent and 28 per cent respectively.

iv. Sex. Even allowing for the higher proportion of women among the elderly as a whole they were over-represented among recipients. The proportions of male and female recipients and residents were broadly comparable.

v. Living Arrangements. Almost half of recipients, 47 per cent, live alone and a further 28 per cent live with a spouse who is also likely to be elderly. Therefore three quarters of all recipients live in elderly households.

vi. Physical Dependency. Recipients were assessed on 5 items reflecting the degree of physical dependency: mobility, dressing, bathing, feeding and continence. Eighty per cent of recipients were described as fully ambulant or usually independent and only 14 per cent as able to walk with aids, bedfast or chairfast. The vast majority were described as having no problems with dressing, none required help with feeding and only 3 per cent were described as inadequate in this activity. The activity with which the home help recipients required most help was bathing - some 13 per cent were described as requiring bathing. Incontinence was not common. Only 4 per cent were described as being incontinent of urine or doubly incontinent.

vii. Mental Disturbance. Prevalence of behaviour reflecting mental disturbance was not high among recipients. The

most significant finding in the 5 items reflecting mental disturbance was that 5 per cent of recipients suffered from short and long-term memory loss.

viii. Total Behaviour Rating. The vast majority of recipients of the service (87 per cent) presented none or only slight behavioural problems. The remaining 13 per cent representing 42 people scored between 10 and 29 on the rating scale and none scored in the highest rating band 30 to 38.

c. Help Provided

i. Time Allocated. Some 40 per cent of households received the service on 5 days per week and 22 per cent on 7 days per week. In total almost three quarters of all households received the service on 5 or more days per week. At the other end of the scale only 13 per cent of recipients received the service on 2 or less days per week. Among the 42 recipients receiving the service on 2 or less days per week approximately 99 per cent were described as having no or only slight behavioural problems and only one presented as having severe problems. Among the 225 recipients receiving the service on 5 days per week 187 (83 per cent) were described as having no or only slight behavioural problems and only 7 (3 per cent) as having severe or very severe problems. Among the 71 recipients getting service on 2 days at the weekend 55 (78 per cent) were

described as having no or only slight behavioural problems and 3 (4 per cent) as having severe or very severe problems.

The average number of hours allocated to these households was 6.4 hours per week. The time allocated ranged from 2 hours to 4 hours to 17 households to 2 households. Only 15 per cent of households had 10 or more hours per week. Among the 71 recipients receiving 4 or less hours per week 69 (97 per cent) were described as having no or only slight behavioural problems and only 2 (3 per cent) as having severe problems. Among those receiving service at the weekend 82 (78 per cent) were described as having none or only slight behavioural problems the remaining 23 as having severe problems.

ii. Tasks performed. All households received help with household tasks ranging from one hour in one household to 14 hours in another. However the number of recipients receiving help with personal care tasks and social care tasks was considerably less and represented 19 per cent and 22 per cent of all households respectively.

The most frequently performed household task was routine/regular cleaning in 98 per cent of households with washing/ironing clothes being carried out in 95

per cent of households and making beds being undertaken in 77 per cent of households. Among the households receiving help with personal care tasks 19 per cent of recipients received help with washing and bathing and 12 per cent with shaving and hairdressing.

The social care tasks most commonly performed were contacting health or social care practitioners. This was closely followed by collecting prescriptions and collecting pensions.

iii. Adequacy of Service. The respondents to the questionnaire were asked to identify if there was any difference between the hours allocated and the hours needed. In the vast majority of cases (80 per cent) staff said that there was no difference. In other words in these households, the amount of service provided was sufficient to meet the needs of the recipients.

iv. Other Help. The home help service, although the main service provided by Health and Social Service Boards to enable old people to remain in the community, is not provided in isolation from other services. Respondents were asked to identify other services received by the recipients. Apart from visits from a social work assistant which one would expect as this group administer the home help service there was little or no other statutory help available to many old people.

Some 32 per cent of recipients received help and visits from voluntary sources but only 17 per cent received visits from a district nurse, 10 per cent received visits from a health visitor, 10 per cent received meals-on-wheels and 7 per cent attended a day centre/social club.

d. Placement

Among the 325 elderly people in receipt of the service the vast majority were considered to be appropriately cared for at home. Only 17 people were considered to require alternative placements. Among the alternatives identified 4 required sheltered housing, 10 residential accommodation and 3 long-term hospital care. In only 3 cases was the alternative being sought.

Decision-making Process

a. Staffing. Staffing in the 3 sub-offices varied considerably. In one of the sub areas there were 19 social work assistants involved in the administration of the service. Whilst for day to day management purposes the staff were responsible to their team leader (senior social worker) and thence to the assistant social worker in charge of a sub-office the major decision on the allocation of the home help service rested with the home help organiser at the district headquarters. In the Strabane and the Limavady sub areas the scale of operations was much

smaller. In Strabane there were 9 social work assistants involved in the administration of the service reporting to a team leader and thence to the sub-office manager. In Limavady there were 4 social work assistants involved spread between 2 teams of staff.

b. Procedure. The main common thread running through the procedures in each of the 3 sub-offices was that the referral for the service is accurate and that there is little need for further assessment. It would appear that referral is not investigated in any great detail with the referring agent whether this is an applicant, a relative, a primary health care worker or member of hospital staff. Referrals appear to be taken at face value and once received are processed in an automatic fashion without any critical appraisal. In Londonderry this type of procedure is particularly marked but in Limavady and Strabane there is a meeting to consider cases. However, the impression gained from discussion with the managers concerned was that this meeting was designed to endorse the activities of the worker dealing with a case to ensure some consistency of approach to the allocation of hours rather than to question or assess the real need for the provision of a service.

Some reference was made to weekly meetings in Limavady and Strabane which were designed to facilitate the assessment of cases, the allocation of hours to a case

and the review of cases. There was no systematic review of cases and where review was mentioned this was more likely to be in connection with the changed circumstances of a recipient eg deterioration in condition or admission to hospital of a spouse.

c. Legislation. The legislation governing the provision of the service is the Health and Personal Social Services (Northern Ireland) Order 1972. This legislation had little influence on decision-making.

d. Circulars/Guidance. The Western Board in whose area the study was conducted had issued no guidance or criteria which would assist in determining the allocation of the service. All managers were aware of the circular issued by the Department of Health and Social Services outlining the model scheme but this also appears to have little influence on decision-making. It was generally criticised as being open to individual interpretation.

e. Definition of Risk. The concept of risk is subject to many interpretations and the changing nature of these definitions make for difficulties in formulating criteria for the allocation of services. This can be used as a justification for haphazard allocation decisions and even among 3 managers of the service in one district there was no common definition or no agreement on the idea of risk.

f. Presence of Carer. It may be assumed that the presence of a carer would give an applicant a lower priority for a service. This is not necessarily true. Among the 3 managers interviewed 2 indicated that the presence of a carer would not diminish the priority given to a case. The third manager did suggest that the presence of a carer was influential in deciding how he would approach a case.

g. Alternatives. The consideration of alternative services was largely a matter for the member of staff who dealt with the original referral. However as a general rule this is unlikely to be considered in any systematic or thorough way as the referrals for the home help service are dealt with in an automatic routine way. None of the 3 managers was very forthcoming about possible alternatives. All indicated that these were only considered in a very small number of cases and one suggested that other services might be provided to complement the home help service rather than as alternatives to its provision.

h. Waiting List. Waiting lists in the form of a list of people who have applied for the service but have not received it do not exist in any part of the district. Apart from one sub-office which imposed a temporary embargo on all new cases for a short period none of the managers favoured the idea of waiting lists and they all processed new cases as expeditiously as possible

according to their local procedures.

i. Priorities. The Board had issued no formal statement of policy which is available to the staff and/or the public. Within the district there are no priority groups identified. One manager did suggest that he would give priority to elderly people living alone and geographically isolated. Another manager, however, stated that anyone who made an application and was considered by the social work assistant to be in need would receive a service, even of a very limited kind.

j. An alternative to residential care. The place of the home help service among a range of services designed to prevent admission to residential and other long-term care is well established. There was no agreement among the 3 managers interviewed as to the efficacy of the home help service in providing a suitable alternative to institutional care. Two managers thought, that, even with the low level of service being provided the home help service was instrumental in maintaining elderly people in the community. This was done by the direct service provided via the home help and by the introduction, in a number of cases, by the home help of a whole range of informal care. The dissenting voice doubted the viability of the service in preventing admission to residential care. The service in his view was only capable of giving and maintaining a degree of

independence to elderly people.

k. Rejection of applications. The rejection of requests for a service seems to be unheard of in this district. Some refusals were noted because of possible charges or inappropriate referrals but it would appear that all who applied/were referred for the service and wanted it at the price, if any, that was being charged were considered suitable and were provided with the service.

Discussion

There is growing debate about the quality and purpose of community services provided for elderly people. Up until recently the debate has tended to centre around the quantity of traditional services such as the home help service, meals-on-wheels, occupational therapy, day care and the community nursing services that could be provided to the elderly population. The obvious answer to the growing numbers of elderly people, especially the numbers of very old people, has been to provide for an expansion of existing services - more of the same.

In times of readily available finance such a strategy was possible. However the planning and provision of services must now be undertaken in the financial climate which is far from favourable to the expansion of services whether capital or revenue based. Already the Health and Personal Social

Services are facing growing demands from the elderly population and the real expansion in the number of those over 75 years, and who are most likely to need the community support, has yet to take place in Northern Ireland.

Northern Ireland has yet to face a situation similar to that in the rest of the United Kingdom and the finance needed to meet the growing demand within the present structure of the services is not likely to be available. Financial budgets for health and social services are likely to remain at best at their present level or at worst to decline in real terms. As has been seen in Chapter 4 the level of provision of the home help service in Northern Ireland far exceeds that in England and Wales. Despite this, however, social services are already having to face up to uncomfortable decisions. They can either continue to provide the same services to a smaller percentage of the elderly population or they can spread a reduced service around a larger number of elderly clients.

The results of this small case study raise some fundamental questions about the style and organisation of community-based services for the elderly. One needs to ask if they are meeting the real need in the most efficient and effective way. The review of the main findings from this case study both on recipients and the decision-making process suggests that the present pattern of delivery may not be a satisfactory baseline for the planning and

development of services in the future. There is now more evidence to support an earlier suggestion by this author that the system of procedures - referral, assessment and review - may not be working efficiently enough.

The case study had among its objectives a comparison of service with a measure of need. The results of the study would suggest that there may well be large numbers of elderly people in receipt of the home help service who have no great need of it. Almost 9 out of every 10 recipients were described as having none or only slight behavioural problems and almost one third of all recipients had been in receipt of the service for 5 or more years. Perhaps this was because they once required a service during a period of crisis which they survived but might no longer have any need for it. Furthermore even if all recipients of the service were genuinely in need, there appeared to be little or no correlation between the time allocated, whether measured in days or hours per week, and the severity of behavioural problems. It is also worth noting that despite the growing demand for service and the restriction on resources to deliver the service there were no major gaps between the hours allocated and the hours needed. Finally if the service was being directed at those who were sufficiently frail or disabled and on the verge of admission to residential or other long-term institutional care one would expect a whole range of other services to be mobilised and targeted to those individuals. There was no evidence of this.

The study of recipients raises questions about how far the services elderly people currently receive are a reflection of their real need, and whether the systems and procedures used to deal with referrals and assessment are as efficient as they will need to be in the future. The part of the case study on decision-making looked at these aspects. While referrals as such were not examined information was sought about refusals during a 12 month period. The evidence provided from the interviews with managers suggest that no referrals were rejected during this period which indicates that every case referred for the home help service during this period was considered, after assessment by a social work assistant and approval by a senior member of staff, to be an appropriate referral. This might suggest that each social work assistant or whoever accepts the referral gets it right at the first attempt. However the situation is perhaps not as straightforward as might appear at first sight. An examination of a small number of referral forms during the preliminary stages of setting up the case study suggests that the information which accompanies the referral for a service is almost always minimal. A second point is that a significant proportion of referrals come from lay people, the prospective client himself, or a relative, friend or neighbour. Fifty four per cent of all referrals came into this category.

Thus the absence of detail at the time of referral and the source of referral make it all the more remarkable that all

prospective clients referred for the home help service were provided with the service following an assessment of need by a social work assistant. The important issue to emerge from this is that the decision to allocate the home help service is taken not by someone within the Social Services Department but by someone outside the system - often a member of the general public.

This raises questions about the kind of assessment being undertaken by the social work assistants charged with this task. The absence of other services being received by the majority of recipients of the home help service would suggest that the social work assistants are not taking the request for this service as an indicator of need on behalf of the elderly person, and undertaking an open-ended, all embracing assessment which might identify other more relevant needs, and which might presumably be met by another service or package of services. The suggestion, therefore, is that prospective clients were offered a service without any proper assessment (although some screening may take place) and the high proportion of clients receive what they ask for or what is requested on their behalf.

This examination of the recipients of the service and the decision-making process leads one to the conclusion that there is evidence to show that a significant number of elderly people may be over-provided with community services

for a number of reasons. Firstly, the quality of assessment is poor; secondly, the absence of any agreed definition of the concept of risk leads to a fear, on the part of fieldworkers, of leaving an old person on his own. This results in the home help service becoming a very expensive monitoring service. Thirdly, proper re-assessments sometimes do not take place following a crisis from which the elderly person made a full or partial recovery; and finally, the communication between professional groups within and between agencies can be poor leading to an elderly person receiving an over abundance of poorly co-ordinated services.

The end result of provision of services in this way can be a thorough undermining of the independence of an elderly person, perhaps hastening their decline while denying crucial services to other elderly people in need.

RESIDENTIAL CARE

a. Current Residents

The characteristics and presenting features of current residents were examined in terms of

i. Age. Twenty eight per cent of all residents were 85 years or older. This is less than any other study in the rest of the UK and considerably less than another Northern Ireland study by this author which found

39 per cent in this age range.

ii. Sex. Even allowing for the higher proportion of women among the elderly as a whole, they were over-represented in the homes. However the proportion of women in homes in this area, 63 per cent, is considerably less than the proportion found in the other local study, 86 per cent.

iii. Length of stay. Almost one third of all residents had been in residence for more than 5 years. Thirteen per cent had been in residence for less than 6 months. The corresponding figures for the other local study were 25 per cent and 20 per cent respectively.

iv. Residence prior to admission. Less than half, 43 per cent, of residents were admitted from their own homes and 33 per cent from some form of hospital provision. These figures are different from the other local study where a much smaller proportion, 29 per cent, were admitted from their own homes and a large proportion, 37 per cent, from hospital provision.

v. Living Arrangements. Almost half, 46 per cent, of all residents lived alone prior to admission and a further 5 per cent with their spouse only. Figures for the other local study are 42 per cent and 8 per cent respectively.

vi. Physical Dependency. Residents were assessed on 5 items reflecting the degree of physical dependency; mobility, dressing, bathing, feeding and continence. The proportion of non-ambulant residents was similar to the other local study at 8 per cent. The proportions of residents who found major difficulties with other activities were dressing - 17 per cent; feeding - 11 per cent; bathing - 61 per cent; and 2 per cent of residents were described as doubly incontinent.

vii. Mental Disturbance. Prevalence of behaviour reflecting mental disturbance was reported in all 3 districts of the Board. Throughout the Board's homes some 15 per cent of residents were described as having short and long-term memory loss. However this is only half the population of 30 per cent found in the other local study. The proportions of residents having difficulties with orientation, communication, restlessness and co-operation were small.

viii. Total Behaviour Rating. Half the residents in the home presented no or only slight behavioural problems compared with 30 per cent for the other local study. At the other end of the spectrum only one per cent of residents presented very severe problems compared with 2 per cent in the other local study. The mean score (range 0-38) for residents in each of the 3 districts was 8.8, 10.6 and 14.1 giving 10.7 per cent for the

Board's area as a whole. The mean score in the other study was 12.8. The differences in the mean scores may be accounted for by differences in the population from which the elderly people were drawn or differences in the admission policies in the districts. This latter point will be explored later.

ix. Appropriateness of Placement. One of the main objectives of the study was to ascertain whether there was any significant number of residents who were misplaced. Throughout the Board's area 99 residents, 19 per cent of the total, were considered to be misplaced. This figure masks considerable variation between districts which show proportions of 9 per cent, 15 per cent and 36 per cent. The figure misplaced from the other local study was 12 per cent.

b. Admissions

The characteristics of those elderly people admitted to residential homes on a long-term basis were examined in terms of

i. Age. Among those admitted 31 per cent were in the age range 65 to 74 years and 16 per cent were 85 years and over. The older age group were over-represented in the admission group confirming the pattern found in earlier studies. However, the proportion of very old people, 16 per cent, is considerably less than in another local study which showed that 29 per cent of admissions were

in this age group.

ii. Marital Status. Eighteen per cent of these admissions were married which is considerably in excess of the proportions found in other studies ie 6 per cent and double the proportion found in another Northern Ireland study.

iii. Sex. A higher proportion of men was found among this group of admissions than would have been expected from other national studies. The proportion of men admitted, 43 per cent, corresponds very closely with the proportion of men in the total elderly population in the area, 45 per cent. In the other local study on admissions only 17 per cent were men.

iv. Place from which admitted. Sixty six per cent of admissions were from their own homes and almost one quarter from some form of hospital setting.

v. Method of admission. The vast majority of people (73 per cent) were admitted routinely from the waiting list. The remainder were either admitted as emergencies or urgently from the waiting list.

vi. Living arrangements prior to admission. Among the residents living in the community at the time of admission just over half (53 per cent) lived alone and

almost one third (29 per cent) lived with their children.

vii. Length of time since application. Only 2 people had to wait more than 12 months for admission. The majority, 69 per cent, were admitted in less than 6 months from the date of application.

viii. Person initiating application. Relatives and hospital staff are the 2 groups most likely to trigger an application for admission to a home. In only 11 per cent of cases was the application initiated by the elderly person.

ix. Health. Information on the health of those admitted from the medical certificate shows that the majority presented no or only slight behavioural problems. Only a small proportion of residents were reported as having severe physical problems or displaying severe mental disturbance.

x. Services provided at the time of admission. Among the 34 people living in the community at the time of admission the provision of community services was very sparse. Less than half were in receipt of the home help service; 4 attended a day centre and only one received visits from a district nurse.

xi. Reasons for Admissions. The 2 major reasons for admissions to residential homes were "personal" and "family cases". Forty nine per cent of residents were admitted for reasons associated with their ability to function at home and 35 per cent because of some aspect of family functioning.

c. Decision-Making Process

i. The allocation of places. There was a panel in only one of the 3 districts surveyed. This panel had a dual function of assessment and allocation but the decision to submit an application was that of the individual social worker. All applications were submitted to the panel for discussion and the social worker or social work assistant dealing with the case attended to represent the applicant. In the second district a panel was convened for allocation assessment only. At the meetings of the panel case assessment was minimal; it was assumed that once a case was placed on the waiting list an assessment of need had been completed. Consequently "assessment" was usually one of the overall situation, ie other cases, situation in the home rather than a detailed discussion of individual cases. No categorisation took place. This was done by the residential and day care manager beforehand by selecting a small number of cases from the waiting list for consideration. Another variation of this approach was found in the third district. In the event of a

vacancy occurring in a home a simple straightforward procedure was put into operation. A name was selected from the waiting list on a chronological basis and the place offered to that applicant. Applicants in this district were not assessed in any way by any member or members of the residential and day care management team. It was assumed by them that once an application form had been completed and submitted by a social worker or social work assistant that a need for residential care had been established. This need would be met as and when a vacancy arose. Thus within the Board one identified 3 types of procedures.

- assessment and allocation by a panel;
- place allocation assessment only; and
- placement from a waiting list.

ii. Legislation. The Health and Personal Social Services (Northern Ireland) Order 1972 appeared to have little influence on decision-making. All managers were aware of the wording of the Order but it was of little value.

iii. Circulars/Guidance. The only departmental circular mentioned by one manager was one dealing with arrangements for health care. This was considered to be useful in considering eligibility but was not considered useful by other managers. The Board had issued a paper setting out criteria for admission and

a statement of philosphy of residential care for the elderly. Knowledge about the existence of and contents of these papers was not universal and therefore of dubious value in reaching decisions about the allocation of residential places.

iv. Presence of a Carer. It is a common assumption that the presence of a carer gives an elderly person lower priority for a place in a residential home. All managers agreed that the presence of a person caring for an applicant was taken into account but this did not mean that lower priority was automatically accorded to such an applicant. It was suggested that strain between carer and applicant could be a factor in according higher priority to an application for care.

v. Consideration of Alternatives. In one district this is partly governed by the functions of the panel which deals with assessment and allocation. However, generally the consideration of alternatives is held to be the task of the social worker/social work assistant. In all 3 districts the managers considered that alternatives are likely to be one or more of a range of existing domiciliary and/or day care services. Given the extent of the development of the services in many localities throughout the Board's area, and the pattern of services currently being provided to new entrants to residential care in the area, there must be

considerable doubt about the viability of alternative packages of care which would maintain an elderly person in the community at a reasonable standard.

vi. Balance in the Home. The need to balance the characteristics of a potential resident against the dependency levels currently in a home is important. For example, design features such as width of corridors may make it essential to restrict the number of wheelchair users in a home in order to avoid congestion. However, all managers said that there was no attempt to achieve a balance in the home in terms of dependency or other features. One did suggest that the residents would reflect the demographic pattern of the locality in which the home was located.

vii. Hospital/Community Ratios. There is no explicit policy on this but one manager did suggest that she attempted to balance admissions by taking 50 per cent from the community and 50 per cent from hospitals.

viii. Financial Situation. A good financial situation did not render anyone "ineligible" for Board homes. Consequently anyone could be considered and while managers indicated that some applicants with means may be advised that a place in a voluntary home, if available, might be cheaper the choice of home remained with the applicant.

ix. Waiting Lists. Waiting lists operate in all 3 districts and in 2 districts the lists are sub-divided. In one district the concept of "urgent" applications was used and in another there were "active" and "non-active" sections. However, in all 3 districts length of wait did not give any priority. How far this was communicated to applicants, relatives and other referrers was not clear.

x. The applicant's wishes. Meeting the applicant's wishes for a particular placement is an ideal which all managers accepted. However, the location and design of homes meant that it was not always possible to meet the applicant's desire for a particular home or the wish for a single room.

xi. Emergency Admissions. There was little variation among the managers in the definition of emergency with the notion of "risk" being incorporated in it, in all 3 districts. It is interesting to note however the low level of emergency admissions.

xii. Swop Systems. For many years the swop system has been an item of contention. It has been described by opponents as an inhumane horse trading and by its supporters as a means of making the best use of limited resources. The districts studied represented this spread of opinion. Two districts were emphatic that

they would not operate a swop system and the third was prepared to use such a system with some guarantees built in.

xiii. Medical Assessment. Medical assessment was carried out throughout the Board's area in a uniform way. The same medical certificate was used in all 3 districts and the system appeared to work well although the medical personnel involved do not take part in any discussion about the "fitness" of applicants for residential accommodation.

xiv. Incontinence. All 3 districts were willing to consider incontinent applicants. The important issue to be considered was the management of the problem and if staffing and other facilities eg sluicing arrangements were available then admission of an incontinent applicant was possible.

xv. Self-Care Ability. Throughout the Board's area the managers of residential care suggested that only those people who were bedfast and totally dependent upon staff for a whole range of activities could not be admitted. Persons who had difficulty in one or more of the following activities - getting in and out of bed, washing, dressing, feeding, toileting and mobility would be admitted. However, the results of the study of current residents would suggest that few who are

admitted to homes in this area have this difficulty.

xvi. Mental State. The mental state of applicants is dealt with in the medical assessment completed at the time of admission or application. The only states that appear to cause difficulties in ordinary residential homes are continual wandering and aggressiveness.

xvii. Definition of Risk. The constantly changing definition of risk illustrates some of the difficulties in formulating admission policies. This may be used, in part, to justify apparently haphazard admission decisions. Physical risk would appear to give a person greater priority for a place than social risk. This would tend to confirm the suggestion that residential homes have lost their purely social care function and raise the question whether those at social risk are receiving adequate resources.

xviii. Rejection of Applications. Rejection of applications for admission to homes is virtually non-existent in this area. It would appear that once an application form had been completed and submitted to the residential and day care management section the major decision had been taken and admission to the home would take place in due course when a place became available unless it was refused by the applicant.

Discussion

In common with other industrialised countries the United Kingdom has experienced a rapid expansion in the numbers of elderly people. Whilst there will be little change in the total number of elderly people up until the end of the century the proportion of people over the age of 75 will continue to increase before levelling off. The implications of these demographic trends have been widely recognised in recent years. Heavy demands are placed on both services and on families by the large number of people whose poor health and inability to care for themselves necessitates 24 hour supervision. For many such people constant support and supervision is not available in their own homes, and in most cases the only alternatives available are hospitals or residential homes. The growth in the number of people who require long-term institutional care has not been accompanied by a corresponding increase in the provision of hospital and residential facilities. Consequently, one expects that both types of provision have come under increasing pressure to cater only for those most in need.

Residential homes for the elderly provided by local authorities were originally conceived as places where old people might choose to spend the last years of their lives in moderate comfort and security in the company of others. Many of the Poor Law Institutions which were designated as residential homes were not conducive to the creation of a satisfactory environment, but it was felt that the purpose-

built homes which gradually replaced them would meet the need. In practice, residential homes have frequently been unable to serve the purpose for which they were originally intended and they have encountered many difficulties in providing an appropriate degree of care and supervision combined with a homely atmosphere. Despite policy pronouncements to the contrary they have found themselves caring for many chronically sick and disabled people who might have been expected to have gone into hospitals, although they have also continued to care for many others who are mentally fit and well.

Therefore, the combination of demographic changes and the problems encountered in providing residential care for the elderly have caused considerable attention to be devoted to questions of policy and practice in residential care. The need to review the role of residential homes has been further stimulated by the national economic difficulties during recent years and the escalating capital and revenue costs of building and running homes. On the one hand, attention has been focussed on the provision of community services which are often seen as a lower cost alternative to residential care and on the other hand, increasing emphasis has been placed on the need to concentrate expensive residential services on those people most in need.

The first aim of this case study was to examine the characteristics of residents and to ascertain whether there

was any significant number of residents misplaced. The findings on residents have been reviewed earlier and could be briefly summarised in relation to other studies by suggesting that residents in this area are younger; are more likely to be male; to have lived alone; to have no or only slight behavioural problems and have a one in five chance of being "misplaced".

Official guidance on institutional provision for the elderly suggests that different types of accommodation are appropriate for different categories of old people. Those whose physical health necessitates continuous medical or nursing care should be cared for in geriatric wards, those suffering a degree of mental illness or infirmity which warrants medical or nursing care in psychiatric wards, and the remainder, whose condition does not warrant specialised health care, but who are unable to live in the community, should be cared for in residential homes. Such statements are, however, of little practical help in determining appropriate placement, since they beg the question of what degree of illness, infirmity and dependency warrant particular forms of care. Nevertheless, the general philosophy of providing specialist care for different categories of old people has caused considerable attention to be devoted to the appropriate placement of individuals. A number of studies of the elderly in residential care adopt the view that it is possible on the basis of a measure of the individual level of physical and mental functioning to

determine appropriate institutional placement. Whilst some elderly people are judged to be appropriately placed in non-specialist residential homes, others are considered, by virtue of severe physical and/or mental illness or impairment to require more specialist care. A third group is judged not to require institutional care at all and it is suggested that these people should be discharged to their homes, the homes of relatives or sheltered housing.

A similar approach has been adopted in this study but in addition to using functional capacity, staff assessment of which residents could cope in other settings was used. The main finding is that there is a significant amount of "misplacement" in homes for the elderly and while a number were thought to require placement in hospital provision almost half of those who were considered misplaced were considered suitable for placement at home. This finding has important implications for the use of residential homes in the future and leads to consideration of the pattern of admissions to homes and the policies and procedures which govern the allocation of these places.

The main objectives of looking at admissions to residential care and the decision-making process were

i. to determine the main reason for admission of elderly people to residential care;

ii. to examine stages in decision-making; and

iii. to analyse procedures and policies concerning the allocation of places.

The sample of admissions studied showed that those being admitted to homes in the area compared to other studies, are younger; more likely to be male; more likely to be married; to be admitted from their own home; to be admitted routinely from the waiting lists; to have no or only slight behavioural problems; to have been referred for admission by a relative or health care worker and to be in receipt of very little support from community health and social services at the time of application or admission.

The present pattern of use of residential homes and the pattern of admissions to these homes raises some serious questions about the future use of a resource which because of the present financial circumstances is unlikely to expand in the future. As with the home help service one needs to ask if the residential services for the elderly are meeting real need in the most efficient and effective way. There must be some doubt, arising from the review of the main findings from the case study, if the present pattern of allocation of places is a suitable baseline for considering the use of residential homes in the future. There is now sufficient evidence to support an earlier suggestion by this author that there is a significant degree of misplacement in

homes, that the type of people being admitted to homes will perpetuate this degree of misplacement and that the procedures of admission - referral, assessment and review - may not be working efficiently enough.

The part of the study dealing with decision-making looked at procedures for referral, assessment and review and while referrals as such were not examined information was sought about refusals during a 12 month period. The evidence provided from interviews with managers shows that only 4 referrals were rejected during this period which suggests that almost every case referred for residential accommodation, after assessment by a social work assistant or social worker and approval by a senior social worker proved to be an appropriate referral. However, the examination of the application forms and social reports on new admissions would not support such a view. The information contained on application forms was scant and many of the social reports which accompanied these forms could best be described as laconic. Furthermore it is worth noting that a significant number of referrals come from health care staff or the relatives of applicants. If one combines the referrals from relatives and self referrals this accounts for 67 per cent of all referrals.

Therefore the absence of detail about the circumstances of new applicants and the source of the referral make it all the more remarkable that nearly all prospective residents

referred for residential care were provided with the service following an assessment of need by a social work assistant or social worker. As with the home help service case study the important issue to emerge from this is that the decision to allocate a place in a home is taken, not so much by someone within the Social Services Department but by someone outside - perhaps a member of the general public who perceives himself/or a relative or friend to have a need for a service which is available.

This again raises fundamental questions about the kind of assessment being undertaken by the social work assistants/social workers undertaking this task. The absence or poor provision of a range of community support services, both health and the personal social services, to prospective residents would suggest that social service staff are not taking the request for this service as an indicator of need on behalf of the elderly person or undertaking a comprehensive assessment of the applicant's needs which might identify other options for meeting these. The suggestion is that, as with the home help service study, prospective residents are offered the service without any proper assessment, although screening of applicants may take place, and the high proportion of clients simply receive what they ask for or what is requested on their behalf.

This examination of residents and the decision-making process leads one to the conclusion that there are

significant numbers of elderly people who may be in receipt of a service far in excess of that required by their needs. The reasons for this are broadly similar to those advanced for the over provision of community services. Firstly, the quality of assessment is poor; secondly the absence of any agreed definition of "risk" leads to a fear of leaving the old person on their own; thirdly, re-assessments are not undertaken after admission and fourthly the absence of a properly co-ordinated package of care would suggest that communication between the professional groups is not as good as it should be. The end result of admission policies which allow those with minimal needs to occupy and fill up scarce residential places will be to deny these places to others with more pressing needs.

CHAPTER 9

DISCUSSION

Policy

State community care policies have traditionally taken the form of the provision of help and support in non-institutional settings, usually in the individual's own home. They are intended to keep the individual in the community and out of an institution.

Community care has been an explicit policy goal in the United Kingdom since the end of the 1940s but it was not until the late 1950s that opinion against institutional care developed and a policy of community care emerged. In 1958 the then Minister for Health stated that the "underlying principle of our services for the old should be this: that the best place for old people is in their own homes, with help from the home services if need be." (1) The Hospital Plan of 1962 (2) was said to depend on the expansion of community care for its success and in 1963 the Report "Health and Welfare" (3) described the needs of the elderly in the following way:

"Elderly people living at home may need special support to enable them to cope with their infirmities and to prevent their isolation from society. As their capabilities diminish, they will more often require such services as home help, laundry services, meals cooked ready for eating and chiropody. Loss of mobility brings the need for friendly visiting, transport to social clubs and occupation centres, and arrangements for holidays. When illness is added to other infirmities

they need more home nursing, night care, and help generally in the home. In terminal illness, an elderly person may for a limited period need considerable help from many domiciliary services."

Local authority services were increased considerably in the late 1960s and early 1970s following the publication of the Seebohm Report (4) and the Report of a Survey of Handicapped People carried out by the Office of Population Censuses and Surveys (5). The latter report confirmed the findings of independent researchers concerning the lack of domiciliary services: only 16% of the very severely handicapped, the majority of whom were elderly, were getting home help assistance.

The explicit commitment to community care was repeated in the 1976 Consultative Document "Priorities for Health and Personal Social Services in England" (6). "The general aim of policy is to help the elderly maintain independent lives in their own homes for as long as possible. The main emphasis is then on the development of the domiciliary services ... ". In the Way Forward (7) in 1977 the Department of Health and Social Security announced the diversion of £6m from capital expenditure in 1977/78 to domiciliary services in response to comments on the previous document. In addition there was a hope of a slightly higher rate of growth in such services for the elderly than had been envisaged in 1976.

The goal of community care has also been postulated in various Acts of Parliament. These include the National Assistance Act 1948, Mental Health Act 1959, Health Services and the Public Health Act 1968 and the Chronically Sick and Disabled Persons Act 1970. Despite the

reiterated commitments of successive Governments the policy of community care remains a precarious one. The explicit goal has been impressively stated but at the same time it has been ambiguous and it has been claimed by many that insufficient means have been provided to achieve the goal. This will be considered later but first it is important to examine the concept of community care on which public policy has been based, since one of the most striking features of the continued official commitment to this goal has been the confused relationship between the meaning of community care in public policy statements, its meaning in the actual policy carried out and the sense in which politicians and administrators use it.

It has been suggested by Abrams (8) that the possibility of community care in the sense of help, support and protection provided by lay members of society proceeds as state capitalist societies develop. Community care can be re-interpreted in public policy as care in the community supported by welfare workers and even this goal has been re-interpreted from care in the family home to care in a range of settings "in the community", including certain types of residential and hospital care (9).

Therefore, rather than reflecting a policy of deinstitutionalisation the concept of community care has been broadened to encompass residential institutions. It now also includes institutional treatment, institutional care and community treatment. Thus, community care policies themselves may create very limited constructions of "community" and "care". These limited definitions in turn constrain possibilities for change beyond the boundaries defined

by policies. Such definitions may be in part responsible for the pattern of service delivery which is now evident.

Despite its various re-interpretations, some politicians still use community care in the sense of care by the wider community. The policy was most recently restated in 1983 in the circular on care in the community (10). As part of its strategy towards the elderly it is the Government's aim to keep elderly people active and independent in their own homes and to ensure that people are not kept unnecessarily in hospital for long periods.

If one looks at the actual provision of community care facilities and personnel, there is a considerable amount of research in Britain which shows a wide gulf between intentions and practice (11). In the face of demographic changes and the consequential need for domiciliary services and the expectations of clients and service providers encouraged by official exhortations, the Government has not provided local authorities with the resources to meet these needs. The home help service is considered the most important form of domiciliary care provided by local authorities and elderly people comprise most of the clientele. As long ago as 1962 Townsend (12) suggested that the ratio of home help to elderly should be increased to meet outstanding need to 15 per 1,000 and then to 20 per 1,000 by 1973. In 1972 the Department of Health and Social Security gave specific advice to local authorities on the provision of the home help service (13) and recommended a guideline of 12 per 1,000 elderly population. However, by 1980 the local authorities were 44% short of the guideline and there was great variation in the extent to which individual

authorities met the guideline (14).

Despite the shortcomings of local authorities in meeting the targets set for this vital domiciliary service and other community support services such as meals-on-wheels and day care, successive Ministers of Health and Social Security have re-affirmed their commitment to a policy of community care for old people. In 1978 Department of Health and Social Security policy was emphatically spelled out as "the primary objective of the departmental policies toward the care of the elderly is to enable old people to maintain independent lives in the community for as long as possible. To help achieve this, high priority is being given to the development of domiciliary provision and the encouragement of measures designed to prevent or postpone the need for long-term care in hospital or residential homes" (15).

This more recent statement accords quite well with the earlier quotation from "Health and Welfare" but there still remains a sense of ambiguity about the policy which influences the activities of those organisations and practitioners charged with the direct implementation of the policy.

The commitment to community care enunciated in numerous statements and documents eminating from the Department of Health and Social Security in London has been mirrored in Northern Ireland by similar statements in Circulars, Memoranda and Planning Statements issued since the late 1940s. The most recent report on services for the elderly which was endorsed and issued by the Department as the basis for planning for this group for the future adopted a number of general principles which

should be observed in providing services for the elderly. These are:

- respect for individuality in the manner in which services are provided so that elderly people may be helped to live independent lives for as long as possible;

- attention to fostering a healthy public attitude to elderly people and their needs which encourages them to realise their full potential, irrespective of age;

- acceptance of the fact that elderly people, like those in other age groups, are entitled to necessary medical and nursing treatment and should be encouraged to seek that treatment so that they can maintain their activity and well-being for as long as possible;

- the right of elderly people, whether living in their own homes or in residential care, to take decisions about their own lives, even if this means that in their ordinary round of daily living certain risks are taken;

- full recognition of the need to give families the support they need to go on caring for their elderly relatives;

- the attachment of a high priority to supporting and co-operating with voluntary organisations and community groups which help in promoting the welfare of elderly people.

The report concluded by stating, inter alia, that "high priority

should be given to ensuring that adequate help from the community services is given to elderly people who most need it to enable them to remain in their own homes".

Earlier in the chapter reference was made to research which identified a wide gulf between policy intentions and practice and by way of example reference was made to the provision of the home help service. This service will be used to compare the situation in Northern Ireland with other parts of the United Kingdom.

At 31 December 1974, just over one year after the reorganisation of Health and Personal Social Services, there were 10,905 people in receipt of the home help service. By 1983 the number of recipients had risen to 28,023 a staggering 159% increase. In the financial year 1974/75 gross expenditure on the service amounted to £4.6m and by 1983/84 this had increased to £16.7m. Expressed in constant terms (1974/75 prices) by reference to movement in the Retail Price Index this amounted to an increase in expenditure in real terms of 26%. During the same period the number of home helps employed rose from 10,076 to 12,481, an increase of 23.9%. If most of the recipients are elderly the best method of comparison is to express the level of service in terms of home helps (whole-time equivalents) per 1,000 elderly. The net result of all the movements in the figures presented is that by 1983 Northern Ireland had 18.5 home helps per 1,000 elderly. Comparable figures for 1983 are not available for other parts of the United Kingdom but the following table provides a useful comparison for 1981/82.

TABLE 1

LEVEL OF PROVISION OF HOME HELP IN UNITED KINGDOM

	Date	Home helps (WTE) per 1,000 population aged 65 and over	Net home help expenditure per head of ennumerated population aged 65 years and over financial year	£
Northern Ireland	30. 6.81	[0]17.4	1981/82	84
Scotland	31. 3.82	13.2	1981/82	54
Wales	30. 9.81	6.8	1981/82	30
England	30. 9.81	6.5	1981/82	29

[0]Estimated Population, 1981 Census

Just as there are wide variations in the level of provision between the English local authorities so there are variations between the Health and Social Services Boards and even within Boards. The level of provision at 30 September 1983 in each of the Boards was - Northern - 14.78 per 1,000; Southern - 25.12 per thousand; Eastern - 18.95 per thousand; and Western - 21.54 per thousand. The disparity within Boards was even more marked. The lowest level of provision in the Northern Board was 9.45 and the highest 20.9. The corresponding figures for the other Boards are Southern - lowest 20.86; highest 30.11; Eastern - lowest 11.05; highest 29.51; and Western - lowest 20.54; highest 22.96.

Despite this comparatively high level of provision, 3 times the rate in England and Wales, there are widespread complaints about the inadequacies of the service. On the other hand the Minister of State at the Department of Health and Social Services has suggested that the high level of expenditure and employment has resulted in the institutionalisation of a good neighbour service and may also have undermined the willingness of the population to care for each other (16). Such statements on the local Northern Ireland scene point to a very precarious and sometimes ambiguous policy of community care even if one is to restrict it to the preventive support provided by social services staff. It is within this policy context that consideration of the effectiveness of policy implementation needs to take place. In doing so a number of major aspects need to be considered. Firstly, the huge expansion of the number of clients allied to the much smaller allocation of finance for the service suggests that a system of rationing must be taking place. If so, what is the impact on other

parts of the service. Secondly, the case studies suggest that the services are not being delivered in the most efficient and effective way. There is poor targeting of services in that some people are given scarce resources from the community service budget and there is some doubt as to their need for them and others are "misplaced" in residential homes when judicious use of community services could have enabled them to remain in their own homes for a longer period. Having ascertained what is happening consideration needs to be given as to why this is so. Finally, in addition to looking at some of the internal reasons for the pattern of service provision the chapter concludes with some speculative thoughts about some of the wider socio-economic factors which may need to be taken into account.

Rationing

In the review of the literature 2 types of rationing were identified - financial and service rationing. The latter was considered to be the more relevant for the present study and it was noted that our understanding of what actually happens is very limited. Three groups of rationing strategy were identified by Parker (17) - restrictive, dilutant and premature termination of services. These strategies were further refined to a 2-fold classification of formal and informal and among the informal mechanisms were delay, dilution and deterrents. In describing the dilutant mechanism Foster (18) suggested that social workers may decide to spend less time with their clients than they judge to be necessary. They rarely inform consumers that they are receiving a diluted service and dilution is therefore a particularly difficult method of rationing to detect and scrutinise.

The statistical material used earlier in this chapter to compare the level of provision in Northern Ireland with that in the rest of the United Kingdom would suggest that rationing on a massive scale is taking place. During the period reviewed the financial allocation for the service increased in real terms by 26% but the number of recipients increased by 159%. The only way in which this huge increase in demand could be met was by widespread dilution of service. One way to measure this is to examine the average hours per case over a period of time. Figures for Northern Ireland are not available but figures from the Armagh and Dungannon District of the Southern Board (the Board with the highest level of provision at 25.12 home helps per 1,000 elderly) demonstrate the point. In December 1975 there were 814 persons in receipt of the home help service; there were 733 home helps employed and the average hours per case were 12.5 per week. By December 1982 the number of persons in receipt of the service had risen to 1,436 (an increase of 76%); there were 1,114 home helps employed (an increase of 52%) and the average hours per case per week had fallen to 7.30 (a decrease of 41%). This dilution of service can be looked at in another way. Although there are no figures for the average hours per case in Northern Ireland the distribution of hours per week allocated to households is available (19). This shows that for all of Northern Ireland 26% of all households in receipt of the service receive less than 4 hours per week. The range between districts is 8% and 57%. At the other end of the spectrum only 7% of households receive 12 or more hours per week and the range among districts is 1% to 22%. This would suggest that the potential for achieving the policy aim of "ensuring that adequate help from the statutory community services is given to elderly people who most need

it to enable them to remain in their own homes" is very limited.

Before going on to consider the idea of poor targeting, it would be useful to consider some of the factors which could contribute to the upsurge in demand for the service. The most obvious factor to look at is the growth of the elderly population and the shift in the numbers in the age groups within that total population. During the period 1971 to 1981 the elderly population in Northern Ireland increased by 22,000 from 166,000 to 188,000, an increase of 13%. Thus the increase in the elderly population in total would not account for all of the increase in demand. However, the older age group are more likely to be in need of the service and during the same period the number of elderly aged 75 years and over increased by 12,000 from 57,000 to 69,000 an increase of 21%. Again this would not be sufficient to account for the upsurge in demand. Another, less tangible, factor which could have contributed to demand has been changes in public expectations leading to clients, relatives and politicians (in the broadest sense) seeing the provision of a home help service as an entitlement irrespective of need or other resources. A third factor could be the change in the model scheme which gave a free service to persons aged 75 and over. This change was introduced in November 1980 but there has been no systematic monitoring of the effect on the demand for the service.

One of the major concepts in the re-organisation of Health and Social Services in Northern Ireland was the programme of care approach to meeting the needs of individuals and groups in society. A critical factor in any programme of care is the relative balance of provision

between the various elements of the domiciliary, community and hospital services which together constitute the overall spectrum of care. Unless services are available in the right balance and there is a realistic range of options at the disposal of professional staff, distortion takes place. The effect of this is that some individuals are misplaced in residential homes and hospitals or are inappropriately given community services to enable them to stay in their own homes.

Given the degree of rationing which has taken place and given the integrated structure for Health and Social Services it might not be unreasonable to suggest that the Personal Social Services staff within the Board might come under increasing pressure to examine their practices and to try to ensure that resources were being directed towards those most in need of help and towards preventing admission to long-term hospital care. The reasons why such pressures are not being applied to the social services department is perhaps to be found in the overall level of health and social service provision in Northern Ireland. This is well illustrated by the reference to the level of acute and non-acute hospital beds. In May 1982 the Northern Ireland Economic Council Report on the Health and Personal Social Services (20) stated that Northern Ireland is relatively well endowed with hospital beds on a population basis, 11.1 per 1,000 population compared to 7.8 per 1,000 in England, but that the occupancy rate was lower than in Scotland and in England. The report concluded that available facilities were being used less intensely than elsewhere in the United Kingdom. In respect of acute hospital beds Northern Ireland is especially well provided with 50% more beds per capita than

England at 4.2 beds per 1,000 population compared to 2.8 beds per 1,000. The report also went on to say that the relatively generous provision of acute hospital beds per capita has to be considered together with long-stay hospital accommodation and pointed out that Northern Ireland also has a large number of long-stay hospital beds compared to England, 14 and 8 geriatric beds per 1,000 elderly population respectively. The justification for higher expenditure on these services is based on equity defined in terms of equal level service for people in equal need. Higher expenditure levels are a direct consequence of higher morbidity rates and greater socio-economic deprivation in Northern Ireland. Despite this attempt to reduce inequality the fact remains that the greater levels of provision which exist in all sectors make it possible for distortions in placement to take place more easily and for personal social services, for example, to be shielded from the outcry which would arise from other professionals if the dilution of the home help service led to increases in demand for placement in scarce acute and long-stay hospital placements. There is no suggestion that such pressure is being directed towards the personal social services as yet.

What then are the implications of this analysis for the integrated structure of Health and Personal Social Services in Northern Ireland?

The placement of many services under one co-ordinated administrative umbrella is an old dream. Amidst all the specialities designed to meet human need, it has always seemed that there should be a place where a person in need can receive help without confusion or delay.

As was stated in the Introduction the re-organisation of Health and Personal Social Services in Northern Ireland was an attempt to achieve a wide range of objectives. These could be stated broadly as a need to array services in new organisational relationships that combine the features of availability and accessibility with those of responsiveness and responsibility.

- availability, in the sense that a person can bring any reasonable problem at a reasonable or unreasonable hour to a highly visible entry point to the system without first attempting to classify himself to the specific type of service he needs;

- accessibility, in the sense that he can reach that entry point within a comfortable travel time and minimal inconvenience;

- responsiveness, in the sense that the system is organised so that the person in need moves expeditiously from the level of general or primary care to more complex and specialised levels of care as his needs dictate;

- responsibility in the sense that the system specifies for whom it is prepared to provide care and designs its services accordingly.

The integration of Health and Personal Social Services in Northern Ireland was in marked contrast to those arrangements elsewhere in the United Kingdom where co-ordination between Health and Personal Social Services has been stressed rather than integration. However, despite the uniqueness of the development it has received remarkably little

attention. Ditch and Morrissey, (21) suggest that "it is one of the major lacunae of the Merrison Report on the National Health Service that so little space was devoted to reviewing the structure, functioning and accountability of the Northern Ireland Board structure". This they suggest is regrettable in that Merrison reviews the arguments for and against the integration of social and health services in Britain and despite the fact that Northern Ireland had been operating such a system for the past 6 years the Report devoted only 3 rather bland paragraphs to this fact.

Brown (22), who, for a period, was a member of the Eastern Health and Social Services Board has reviewed the functioning of the Board and expressed his frustration at its inertness and insensitivity. He is critical of the lack of genuine co-operation between the professions, the tiered structure of administration and the lack of communication between professions and administratives. He concludes his review with a jaundiced quotation from a Director of Social Services - "the advantages of integrating Health and Social Services are like the King's new clothes, invisible but very expensive.".

Another analysis by Kogan (23) suggests that the response of staff to integration was mildly favourable. He suggests that social workers only recently emerging with full-fledged professional status in the care-giving system, definitely benefited from the re-organisation. They were exposed to high standards of professionalism in the health care system and were able to draw up on the much more fully-developed resources of the health care specialities.

At the field work level, social workers and nurses were positive about gains in service delivery for clients. In urban areas, there appeared to be less duplication of service, and joint case review by nurses and social workers was facilitated. Nurses were better able to secure home accommodation for patients prior to discharge with social work assistants.

Because of the Executive Order from the Department of Health and Social Services the social services actually gained budgetary resources relative to the health services after re-organisation. This was a source of satisfaction to social services but was not gladly welcomed in medical circles. According to Kogan the strongest opponents of service integration were medical clinicians and hospital physicians. These doctors argued that social workers did not know how to work on the treatment team, did not relinquish control of cases when medical needs of the patient so dictated, lacked necessary expertise to work with health-related problems and delivered services at greater real cost than traditional health agencies. Resentment was also expressed over the earmarking of funds for social services in the Boards' budget, as this seemed to undermine the efficient planning and priority setting for health care.

A pervasive problem identified was the clash in philosophical outlook, technologies for intervention, the degree of professional experience and training, and perceived target population for services by physicians and social workers. Admittedly, the level of experience and professionalism among the social workers in Northern Ireland compared unfavourably with the medical profession. Social service

administrators argued, however, that physicians were accustomed to deference in the working relationships and passivity in their patients. Social workers were trained to work with clients towards self-sufficiency and were concomitantly less inclined to accept "doctors' orders" without question.

The differences between health care and social service professions posed the greatest obstacles at the systems planning and resource allocation level. Problems were least noticeable at the service delivery level where co-operation between low status groups of women - nurses and social workers, was involved. Finally, it became clear in the Northern Ireland experience that the highest status health professionals had virtually no benefit from integration.

These analyses and the present study raise serious doubts about the effectiveness of the integrated structure for Health and Personal Social Services in Northern Ireland and to some extent for attempts at co-ordination of services elsewhere in the United Kingdom. H unter (24), suggests that it is useful to distinguish between structural integration, involving organisational factors, and process integration, involving behavioural and attitudinal factors. He suggests that while on an organisational chart integration has occurred in varying degrees throughout the United Kingdom it is not so easy to determine the impact of this on professional attitudes or on collaborative practices between professional groups, working within the National Health Service or between health and related services. This study would suggest that the impact is small.

Finally, advocacy of co-ordination grows, in part, out of widespread agreement about the need for more efficient, more comprehensive service delivery. However, emphasis on these potential benefits of co-ordinated service delivery has often overshadowed the need for analysis of potential costs. These may outweigh the benefits and, while it is not possible to be certain about such matters before the fact, much more attention could be paid to an assessment of when, where, and under what circumstances co-ordination and/or integration can be implemented at all.

TARGETING OF SERVICES

The case studies on recipients of the home help service, residents in old people's homes and the decision-making process in relation to the allocation of the services suggested that the services may be poorly targeted for a number of reasons. Among the reasons advanced were poor assessment, a fear or risk on the part of the fieldworkers, lack of re-assessment and poor communication between professionals.

The literature review suggested that the behaviour of lower-level participants in organisations was an important determinant in providing a "fit" between policy intention and implementation. In essence this means that decisions of this group of staff, the routines they establish, the devices they invent to cope with uncertainties and

work pressures effectively become the public policies they carry out. Having ascertained what has happened in recent years in respect of the implementation of community care for the elderly, one needs to consider why this pattern of service provision has emerged over the last decade.

Prior to the re-organisation of the health and personal social services in Northern Ireland in 1973 the responsibility for the home help service rested with the former local authorities. There were only 8 authorities and generally the home help service was administered centrally by a home help organiser who monitored the allocation of hours to households and in the majority of cases took the final decision about the provision of the service. Households were visited and assessed in many cases by the qualified staff, although at that time some authorities were beginning to employ some unqualified staff, welfare assistants to undertake a number of routine tasks with some client groups, eg elderly and physically handicapped people.

Following reorganisation there was a considerable change in the method of administering the home help service. While the number of authorities was reduced to 4 (from the former 8) each district within each of the area authorities became responsible for the administration of the service in its own locality. This meant that there were now 17 districts ranging in size from 30,000 total population to 220,000 population providing a home help service. The administrative structure required in the newly formed areas and districts allied to a workforce which was comprised mainly of young women, meant that there

was a very rapid turnover of newly qualified staff. This had 2 effects. Firstly, it resulted in the recruitment of non-qualified social work assistants in large numbers and secondly the promotion to senior social worker posts of many young and inexperienced staff.

The basic model for the delivery of personal social services within these districts was a team comprised of a senior social worker (team leader) 3 social workers and 3 social work assistants working in a geographical patch. However, the existence of a team under the supervision of a team leader did not, and still does not, ensure that there is a proper allocation of tasks based on the skills available in the team. In general, qualified social workers are involved mostly and at times solely with the care of children whilst the caseloads of unqualified staff are composed mainly and sometimes exclusively of elderly people, especially those in receipt of the home help service and those who have applied for admission to residential care. While the level of intuitive understanding and skill and the experience of many of these staff is undoubted it is highly questionable if untrained staff should carry the level of responsibility that many currently do - supporting families where the care of an elderly person has caused a good deal of emotional and physical strain or working with lone, elderly people in the community who are confused and are a danger to themselves and others. This role is so extensive that they have been referred to as social workers for the elderly.

The general pattern to emerge after reorganisation was for assistants to carry responsibility for 50 to 100 home help cases, most of whom were elderly. They were responsible for assessing the client's need

for the service, recruiting and appointing their own home helps, allocating home help hours and reviewing cases. The 2 arguments advanced by assistants in support of this dual role of social workers for the elderly and home help organisers were (a) their personal knowledge of clients and the home helps facilitated mutually satisfying placements and (b) their close contact with some home helps could often reduce the need for them to visit since they could rely on the home helps to report any change in the client's condition.

As mentioned earlier the person directly responsible for supervising the work of these untrained staff were team leaders. However, because of the rapid turnover of staff many of the people occupying these posts were inexperienced and the arrangements for supervision varied considerably. Some assistants were unsupervised, in some teams they relied on informal consultations and in others there was some modicum of supervision. The absence of supervision could be due to 2 main factors. Firstly, the pattern of social work assistants dealing with the elderly meant that team leaders had very little, if any, experience of social work with the elderly. Secondly, the home help service, for which assistants had responsibility was also an area of work with which team leaders were unfamiliar and in some respects they would have known considerably less about the needs of the clients and the administrative arrangements of a service for which they were managerially responsible, than their junior staff.

The combination of untrained staff, allied to supervision lacking in quantity and quality were 2 powerful determinants of the pattern of service delivery which was taking place in the immediate post-reorganisation period. These factors were significant in

contributing to the absence of assessment and re-assessment of need in individual cases. However, another and not insignificant factor which contributed to the present pattern of services and which is linked to the 2 factors described was the financial allocations to the service. In the immediate post-reorganisation years the financial allocation to the service increased in real terms by some 17% and 11% - considerably in excess of other allocations. This would have facilitated meeting the upsurge in demand and rendered the need for proper assessment and re-assessment less critical.

Finally, a major influence on the situation has been the activity of the trade union movement. Prior to re-organisation the rates of pay for home helps varied between the 8 local authorities from 26.06 pence per hour to 57.23 pence per hour. As with many groups of staff in local authority welfare departments the level of union membership among home helps, who were largely casual part-time employees, was low. Upon reorganisation those unions which represented ancillary and general grades of staff in the health service undertook extensive recruitment campaigns among former local authority staff and the Confederation of Health Service Employees (COHSE) and the National Union of Public Employees (NUPE) were active in recruiting home helps. In September 1974 agreement was reached on the introduction of terms and conditions for home helps working over 21 hours per week with an undertaking that the position of all home helps would be examined. Government pay policy precluded any further negotiation until August 1979 but in December 1980 conditions of service, similar to those enjoyed by full-time home helps and part-time home helps working

21 hours or more per week were applied to all other part-time home helps on a pro rata basis according to the hours worked per week. These negotiations had 3 major effects. Firstly, the cost of the service escalated; secondly, a loss of flexibility in a "good neighbour" service and, thirdly, an increase in the administrative duties of social work assistants. At this point a third union entered the arena - the Northern Ireland Public Service Alliance (NIPSA). This union represents the social work assistants and the clerical staff who are engaged in the payment of home helps. The introduction of terms and conditions of service for home helps led to more administration in recording hours worked and consequential pay arrangements. This led in turn to demands for better staffing levels to deal with the more complex system and, in part, contributed to this union's influence on the availability, or lack of availability, of information on the service. The discussion in Chapter 5 on the conduct of the case study on the home help service is relevant here and 2 other incidents serve to demonstrate this. Recently the Western Health and Social Services Board attempted an examination of the home help service in its area and commissioned an educational establishment to conduct the exercise. The union was consulted about the exercise but so far has refused to co-operate. The grounds on which the refusal is based are not known. In another area a researcher conducting a study of informal welfare sought to interview a sample of home helps about their work. An approach was made to a social work assistant for a list of home helps who would participate. The social work assistant was willing to co-operate but indicated that before doing so she would have to obtain the approval of the union before releasing the names. The net effect of such influences is to produce a rigidity into a service/resource which imaginatively used could

provide good quality community care for many frail and disabled elderly people.

CONCLUSION

The study leaves one with the impression that there are 3 main factors which play major parts in the implementation of policies for the health and social care of elderly people.

The policy pronouncements on community care for this group whilst they are explicit and of longstanding are precarious and in some ways ambiguous. This lack of clarity does not aid effective decision-making by those charged with this task in relation to the delivery of services to individual recipients. Rationing on a huge scale has been taking place in relation to the home help service and this must be linked to the third factor, the quality of decision-making which has taken place. Thus the activities of field level officials are seen to be crucial determinants of policy.

By way of a postscript it is perhaps worth considering some wider socio-economic aspects of the Northern Ireland situation which could be influential not only on the decision-making activities of fieldworkers but also on the ability of Government to pursue fully a policy of community care which involves a shift of resources from hospital provision.

Northern Ireland has nearly twice the level of public employment of the West Midlands (25) and more specifically the expenditure of £660m on health and social services in 1984/85 is the largest single item of

public expenditure in the Province providing for approximately 67,000 full and part-time employees across a large range of disciplines.

Despite this huge investment in public sector employment the unemployment rate is considerably in excess of the national average. In the Eastern Board's area the 1981 Census identified 15.9% of economically active males and 11.4% of females unemployed. The corresponding figures for other health and social service board areas are Southern - 22.7% and 15.4%; Northern - 17.8% and 11.7%; and Western - 26.4% and 15.3%.

Some social work assistants have already reported (26) that the unemployment situation was a significant feature in the demand for home help service. In some areas home helps have persuaded old people to apply for the service and in some circumstances home helps were said to be determined to continue working and contrived to demonstrate the need for the service. In addition there is evidence that shows that the highest level of provision for the home help service are found in Newry and Mourne District (30.11 home helps per 1,000 elderly); North and West Belfast District (29.51 home helps per 1,000 elderly); and Armagh and Dungannon District (26.12 home helps per 1,000 elderly) all of which have pockets of male unemployment well above the average in the Board's area. These are 40.5%; 56.4% and 35.4% respectively. Taken together these factors would suggest that there might be as significant a causal link between the level of unemployment among the general population and the rate of provision of home help service as between the needs of the elderly population and the rate of provision of the service.

The most recent statements of policy on community care have indicated that the Government feels that there are still far too many people unnecessarily kept in hospital for long periods simply because facilities are not available for them in the community (27). The shift from long stay hospital care to care in the community would entail the closure or reduction in capacity of some large hospitals with the consequential loss of employment opportunities. While some occupational groups - for example nurses and therapists - may be able to be redeployed in a community care service, many others - for example laundry and maintenance staff - would not be so easily absorbed. The unemployment levels which already exist together with the absence of alternative employment opportunities, whilst not directly the concern of those management staff charged with the implementation of such a policy would be known to those senior staff living in localities most affected by the decisions and likely to influence the speed and vigour with which such policies are pursued.

These final thoughts do not arise directly from the studies undertaken but are speculative ideas which would be worthy of further investigation.

Finally, as a professional civil servant somewhat removed from the daily round of negotiating practice it is worth being reminded of the realities of implementation succinctly put by J. K. Galbraith (28)

> "On few matters in life is the gap so great as between a dry antiseptic statement of a policy by a well-spoken person in a quiet office and what happens when it is put into practice."

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ANNEX A

SERVICES FOR THE ELDERLY - RESEARCH STUDY IN THE WESTERN HEALTH AND SOCIAL SERVICES BOARD

SCHEDULE OF MEETINGS - 1982

5 February	Director of Social Services
16 February	Senior Management Group with Director of Social Services
18 February	Special Interest Group for the Elderly
1 March	Miss Carson DSSO Enniskillen
5 March	Mr J Armstrong DSSO Omagh
25 March	Special Interest Group for the Elderly
30 March	Mr D Burke Principal Social Worker, Londonderry Limavady and Strabane District
1 April	Mr R Dunseith Principal Social Worker, Londonderry Limavady and Strabane District
21 April	Mrs P McGrath, Senior Social Worker - Omagh District
22 April	Mr T Haverty, DSSO and Senior Management Group, Londonderry, Limavady and Strabane District
29 April	Special Interest Group for the Elderly
29 April	Mrs A Nugent, Social Work Assistant - Omagh District
4 May	Heads of Residential Homes, Londonderry Limavady and Strabane District
12 May	Social Work Assistants - Limavady Sub Office
20 May	Miss F Carson and Fieldwork staff Enniskillen District
25 May	Mrs P McGrath and Elderly Care Team - Omagh District
27 May	Special Interest Group for the Elderly
1 June	Mr B Johnston and Fieldwork Staff - Riverview Office
2 June	Mr V Hutchinson and staff - Limavady Office
2 June	Mr J Stokes and Fieldwork Staff - Strabane Office
4 June	Miss E Browne - Omagh District
10 June	Miss A McLaughlin and Fieldwork staff - Waterside Office
10 June	Mr R Dunseith, Principal Social Worker, Londonderry Limavady and Strabane
11 June	Miss E Browne and Heads of Residential Units - Omagh District
24 June	Special Interest Group - Omagh
29 June	Special Interest Group

2 August	Miss E Hall and Fieldwork staff re Waiting List
24 September	Miss McLaughlin and staff, Waterside Office
27 September	Mrs P McGrath and Mr G Young, Omagh Office
30 September	Special Interest Group for the Elderly
7 October	Mr V Hutchinson and Fieldwork Staff - Limavady Office
14 October	Mr D Burke and Fieldwork staff from Riverview and Shantallow Offices

ANNEX B

Mr S Mackell
Assistant Secretary
Northern Ireland Public Service Alliance
54 Wellington Park
BELFAST
BT9 6BR

29 October 1982

Dear Mr Mackell

On Tuesday 26 October you spoke to me by telephone and informed me that as I had failed to consult the Staff Association in accordance with an agreement of the Social Work Joint Council you would be instructing your members in the Omagh and Londonderry, Limavady and Strabane Districts of the Western Board not to co-operate in a survey of the elderly which I was conducting in these Districts. You confirmed that you had done so when we spoke again on Wednesday 27 October. I have since been informed that your members in the Districts concerned have stopped work on the survey.

My purpose in writing to you is to give you some background to the survey and to ask you, in the light of this information which you did not have when you made your original decision, to reconsider the matter and rescind your instruction to your members not to co-operate with me.

By way of background I should explain that I am a Senior Social Work Adviser employed by the Department of Health and Social Services. In 1979 the Department seconded me to the University of Bath to undertake a one year full-time course leading to the MSc in Public Policy. I returned to my post in 1980 and have among my responsibilities duties in connection with Personal Social Services Research, Development and Planning. On completion of my full-time course I applied to the University of Bath to continue my studies for reading, on a part-time basis, for a higher degree. This application was successful and I enrolled again at the University in October 1981. The research proposal submitted to the University is contained in the first part of the paper (marked A) attached.

While it would have been possible to undertake a purely academic and theoretically based research project I felt that this was not entirely relevant to my own situation nor indeed to the service generally. In order to examine public policy properly I felt there would be considerable merit in undertaking case studies of services designed to meet the needs of the elderly. At this point I feel I should point out that the Department is not funding me to pursue this course of study (I am having to meet the tuition fees personally) although I have been given time to undertake the case studies as well as being given help with printing and the analysis of the information collected.

A number of factors led me to discuss with the Director of Social Services of the Western Board the possibility of conducting my case studies in that area. Discussions were then held with the Senior Management Group of the Board on the

16th February 1982, and this group agreed that I could arrange discussions with their fieldwork and residential staff and seek their co-operation in undertaking this piece of academically based research. Following this meeting and until the present date an extensive series of meetings have been held with groups of staff from all 3 Districts of the Board at which the attached paper was discussed and my request for the involvement of staff was considered. At all these meetings it was made clear to staff the nature and extent of the exercise and 3 staff from the Londonderry Limavady and Strabane District conducted a pilot exercise to test the questionnaire which was being designed for the survey on the home help service. A copy of the final questionnaires designed for this part of the study is attached for your information.

Until your recent intervention the survey was progressing steadily and I have been able to inform my academic supervisor accordingly. The embargo you have placed upon the completion of the questionnaires now puts the whole exercise in jeopardy. The only person to lose out in this situation is myself as the survey has no official standing either at Departmental or Board level. In view of this I would now ask you to withdraw your instruction to members not to co-operate so that the survey may proceed to its successful conclusion.

Yours sincerely

K F McCOY

NIPSA
Northern Ireland
Public Service Alliance
Health and Social Services Boards Division
A Constituent body of the Northern Ireland Pub...
HARDEN HOUSE ...
BELFAST BT...
TEL BELFAST ...

Mr K F McCoy
DHSS
Dundonald House
Upper Newtownards Road
BELFAST
BT4 3SF

Our ref: H/SM/KL

4 November 1982

Dear Mr McCoy

Thank you for your letter dated 29th October 1982. I have noted its contents and will raise it with our Social Service Panel at its next meeting.

I will write to you again after that meeting.

Yours sincerely

Sean MacKell

SEAN MACKELL
Assistant Secretary

NIPSA

Northern Ireland Public Service Alliance

HARKIN HOUSE, 54 WELL
BELFAST BT9 6BR. TELEX
TEL: BELFAST 0232
General Secretary J McCusker

Constituent bodies

Northern Ireland Civil Service Association
Civil Service Professional Officers' Association
Public Officers' Division
Health & Social Services Boards' Division

PRIVATE & PERSONAL

Mr K F McCoy
Social Work Advisory Group
Department of Health & Social Services
Dundonald House
Upper Newtownards Road
BELFAST 4

22 November 1982

Dear Mr McCoy

1 I undertook to write to you following our discussion on Monday 15 November when I had had an opportunity to examine some of the points which you made to me.

2 I understand that the Social Services Panel of NIPSA is next scheduled to meet on 30 November so that contrary to what you had been given to understand a fairly early meeting of that decision making body is planned.

3 Complaints were received from members about the work involved in the survey.

4 NIPSA has had for some time a policy decision in relation to surveys requiring the collection of information and has been particularly concerned about control over the use of that information.

5 Most serious perhaps is the total failure of the Western Health Board to consult with NIPSA at any level about the survey with which you are connected. That represents an abject failure on their part to utilise the proper industrial relations machinery and procedures and it is our view that the Western Board realise that and now adopt a Pontious Pilate attitude.

6 It is quite impossible for co-operation to take place when the Management Side whose responsibility it is have completely failed to act as their role demands and have as a consequence placed you in difficulty. They are aware and have been for some time of NIPSA policy in relation to surveys.

7 I am advised by Mr Mackell that the Social Services Panel will again discuss your survey when it next meets but it is unlikely given a) the failure of the Western Board to consult and b) the NIPSA attitude to surveys that any change in their policy will result.

8 I have no doubt that you will find this information disappointing but I did undertake to enquire into the points you made to me and I have now responded on a basis which will, among other things, make clear that the decision in relation to your survey was not that of Mr Mackell but of our Social Services Panel.

Yours sincerely

Sid McDowell

S McDOWELL
Deputy General Secretary

NIPSA

Northern Ireland
Public Service Alliance
Health and Social Services Boards Division

A Constituent body of the Northern Ireland Public Service Alliance

HARKIN HOUSE, 54 WELLINGTON
BELFAST BT1 6DZ
TEL BELFAST (0232) 661811
General Secretary: J McCusker

Mr K F McCoy
Department of Health and Social Services
Dundonald House
Upper Newtownards Road
BELFAST
BT4 3SF

Our ref: H/SM/KL

6 December 1982

Dear Mr McCoy

As stated in my letter to you of the 4th November, I am writing to inform you of the outcome of discussions by our Social Services Panel regarding the content of your letter of 29th October.

The Panel gave serious consideration to your correspondence but decided for the following reasons that they could not agree to the lifting of our ban on co-operation with your proposed exercise.

The Panel take the view that in the first instance you should have sought to have the matter tabled for discussion at the Social Work Staff Joint Council, which you should be aware is the appropriate body for the consideration of matters relating to Social Work Staffs terms and conditions of employment.

The Panel's view stems from the fact that the requirements of your survey are such that staff would be required to carry out a considerable amount of extra work over and above their normal duties. I am sure that I do not need to remind you of the policy of my organisation on the carrying out of duties additional to staffs normal range of duties.

This is especially so at this point in time when not only do we have a standing policy on the uptake of additional duties but when we have issued instructions to all our members employed by the Board's that they are (1) not to participate in any statistical gathering exercises and (2) that no returns of any nature are to be made to the Department.

I would also add that the Panel was extremely concerned about members being put into a position were they would relate information about clients to a third party which would inevitably threaten client confidentiality.

In closing I would only wish to add that all such surveys and exercises will be treated in the same manner, if proper procedures are not adhered to.

Yours sincerely

Sean MacKell.

SEAN MACKELL
Assistant Secretary

WESTERN HEALTH AND SOCIAL SERVICES BOARD - HOME HELP SURVEY

CENSUS FORM FOR HOUSEHOLDS CONTAINING ELDERLY PERSONS IN RECEIPT OF HOME HELP SERVICE AT 31 OCTOBER 1982

1. HOUSEHOLD IDENTIFICATION _____ [ ][ ][ ][ ] 1

2. DISTRICT/OFFICE ..... [ ][ ] 2

3. DESIGNATION OF WORKER (CIRCLE APPROPRIATE CODE)

Social Worker	1
Social Work Assistant	2
Other	3

[ ] 3

4. LOCATION OF ACCOMMODATION (CIRCLE APPROPRIATE CODE)

Remote in Country	1
In Village	2
In Suburbs	3
In Town	4

[ ] 4

5. WHAT TYPE OF ACCOMMODATION (CIRCLE APPROPRIATE CODE)

Whole House	1
Flat/Maisonette	2
Bedsitter	3
Room in Flat/House	4
Other (specify)	5

[ ] 5

6. WHO OWNS THE ACCOMMODATION (CIRCLE APPROPRIATE CODE)

Northern Ireland Housing Executive	1
Owned by elderly person	2
Owned by elderly person's family	3
Housing Association	4
Private Landlord	5
Other (please state)	6
Don't Know	7

[ ] 6

7. IS THE ACCOMMODATION SHELTERED HOUSING WITH A RESIDENT WARDEN? (CIRCLE APPROPRIATE CODE)

Yes	1
No	2
Don't Know	3

[ ] 7

8. HOW MANY ROOMS ARE THERE IN THE ACCOMMODATION? (EXCLUDE KITCHENS LESS THAN 6 FEET WIDE, HALLS, LANDINGS, BATHROOMS, WCs ETC)

[ ] [ ] 8

[ ]

9. HOW MANY ROOMS ARE CLEANED BY THE HOME HELP

[ ] 9

10. DOES THE HOUSEHOLD HAVE THE USE OF

(a) A flush toilet (WC) with entrance inside the buildings? (circle appropriate code)

Yes - not shared	1
Yes - shared	2
No inside WC at all	3

[ ] 10

(b) A fixed bath or shower (circle appropriate code)

Yes - not shared	1
Yes - but shared	2
No fixed bath or shower	3

[ ] 11

(c) A piped hot or cold water supply (circle appropriate code)

Yes - not shared	1
Yes - but shared	2
No piped water	3

[ ] 12

11. DOES THE HOUSEHOLD HAVE COAL FIRES? (Circle appropriate code)

Yes	1
No	2

[ ] 13

12. WHAT LABOUR SAVING DEVICES ARE THERE IN THE HOUSEHOLD? (Circle appropriate code)

Adequate cooker	1	[ ] 14
Refrigerator	1	[ ] 15
Washing machine	1	[ ] 16
Vacuum cleaner	1	[ ] 17
Other (specify)	1	[ ] 18
.....	1	[ ] 19

13. TASKS PERFORMED BY HOME HELP

Routine/regular household cleaning	1	[ ] 20
Preparing and cooking food	1	[ ] 21
Washing up	1	[ ] 22
Lighting fire and bringing in fuel	1	[ ] 23
Making beds	1	[ ] 24
Washing and ironing clothes	1	[ ] 25
Shopping (incl paying bills and launderette)	1	[ ] 26
Emptying commode	1	[ ] 27
Carrying water	1	[ ] 28

14. DO YOU FEEL THAT ANY OF THE ABOVE SERVICES NOT PROVIDED AT PRESENT ARE NEEDED?
(Circle appropriate code)

Yes 1
No 2 ☐ 29

If Yes give details

.....
.....
.....
.....

15. HOW MANY DAYS DOES HOME HELP COME TO HOUSE?
(Circle appropriate code)

On weekdays 0 1 2 3 4 5 ☐ 30

At weekends 0 1 2 ☐ 31

16. HOW MANY HOURS PER WEEK DOES THE HOME HELP ATTEND

	Hours	
On weekdays	☐	☐☐ 32
At weekends	☐	☐☐ 33

17. HOW MUCH TIME PER WEEK IS ALLOCATED TO

	Hours	Min	
Household tasks	☐	☐	☐☐☐☐ 34
Personal care	☐	☐	☐☐☐☐ 35
Social care	☐	☐	☐☐☐☐ 36
Travelling time	☐	☐	☐☐☐☐ 37
Other activities	☐	☐	☐☐☐☐ 38

18. BEARING IN MIND THE CRITERIA FOR YOUR DISTRICT, HOW MANY HOURS SHOULD BE GIVEN TO THIS HOUSEHOLD

	Hours	
On weekdays	☐	☐☐ 39
At weekends	☐	☐☐ 40

19. WHAT IS THE MAJOR REASON FOR THE DIFFERENCE BETWEEN THE ACTUAL NUMBER OF HOURS USUALLY RECEIVED AND THE NUMBER OF HOURS NEEDED?
(Circle appropriate code)

No difference	1
Household unwilling to afford more	2
Household unwilling to receive more	3
Local shortage of home helps	4
Insufficient hours in District	5
Other (specify)	6
.....	

☐ 41

20. DOES CLIENT MAKE
(Circle appropriate code)

Full payment	1
Part payment	2
No payment	3

☐ 42

21. IS THERE ANYONE IN THE HOUSEHOLD IN RECEIPT OF ATTENDANCE ALLOWANCE?

Yes	1
No	2
Don't Know	3

☐ 43

22. IF "YES" TO QUESTION 21, HAS THIS REDUCED YOUR ALLOCATION OF HOURS PER WEEK TO THE HOUSEHOLD?

Yes	1
No	2
Don't Know	3

☐ 44

23. IF "YES" TO QUESTION 22, BY HOW MANY HOURS PER WEEK?

☐ ☐ 45

THANK YOU FOR COMPLETING THIS FORM. PLEASE COMPLETE A HH2 FORM FOR EACH ELDERLY PERSON IN THE HOUSEHOLD ON 31 OCTOBER 1982 AND ATTACH TO THIS FORM.

IF YOU HAVE ANY DIFFICULTIES OR WISH CLARIFICATION OF ANY POINT PLEASE RING KEVIN McCOY ON BELFAST 650111 ext 384.

ANNEX D HH2

WESTERN HEALTH AND SOCIAL SERVICES BOARD - HOME HELP SURVEY

CENSUS FORM OF ELDERLY PERSONS IN RECEIPT OF HOME HELP SERVICE ON 31 OCTOBER 1982

1	HOUSEHOLD IDENTIFICATION _____ (This should match the household identification number on Form HH1)	☐☐☐☐ 1
2	PERSON'S REFERENCE NO _____	☐☐☐ 2
3	Source of Referral (circle appropriate code) Self referral or relatives 1 Primary Health Care 2 Hospital Health Care Team 3 Social Services Staff 4 DHSS 5 Voluntary Organisation 6 Other (specify) ..... 7 Not known 8	☐ 3
4	Length of time known (circle appropriate code) Approximately how long has this person been known to the Social Services Department Less than 6 months 1 6-12 months 2 1-2 years 3 2-5 years 4 more than 5 years 5 cannot estimate 6	☐ 4
5	Length of time in receipt of HHS (circle appropriate code) Approximately how long has this person been in receipt of the HHS Less than 6 months 1 6-12 months 2 1-2 years 3 2-5 years 4 more than 5 years 5 cannot estimate 6	☐ 5
6	Age Range (circle appropriate code) 65-69 1 70-74 2 75-79 3 80-84 4 85-89 5 90-94 6 95-99 7 100 and over 8	☐ 6

7 Sex (circle appropriate code) Male 1 Female 2		☐ 7
8 Marital Status (circle appropriate code) Single 1 Married 2 Widowed 3 Separated/Divorced 4 Don't know 5		☐ 8
9 Living Arrangements (circle appropriate code) Lives alone 1 Lives with spouse only 2 Lives with spouse and children 3 Lives with children 4 Lives with brothers and/or sisters 5 Lives with other relations 6 Lives with others 7 Don't know 8		☐ 9
NOTE: THE NEXT QUESTION SHOULD ONLY BE ANSWERED IF QUESTION 9 WAS CODED 1. "Lives alone".		
10 If the elderly person lives alone is there anyone living nearby who may be called on by the elderly person in an emergency? (circle appropriate code). Yes 1 No 2 Don't know 3		☐ 10
11 Is the old person's bedroom on the same floor as living rooms? (circle appropriate code) Yes 1 No 2		☐ 11
Behaviour Rating of Elderly Person PLEASE CONSULT THE SPECIAL NOTES OF GUIDANCE BEFORE ATTEMPTING TO COMPLETE QUESTIONS 12–21 ALL THESE QUESTIONS SHOULD BE ANSWERED		
12 Mobility (circle appropriate code) Fully ambulant including stairs 0 Usually independent 1 Walks with supervision 2 Walks with aids or under careful supervision 3 Bedfast or chairfast 4		☐ 12

13	**Dressing** (circle appropriate code) Correct Imperfect but adequate Adequate with minimum of supervision Inadequate unless continually supervised Unable to dress or to retain clothing	0 1 2 3 4	☐ 13
14	**Feeding** (circle appropriate code) Correct unaided at appropriate times Adequate with minimum supervision Inadequate unless continually supervised Requires feeding	0 1 2 3	☐ 14
15	**Bathing** (circle appropriate code) Washes and bathes without assistance Minimal supervision with bathing Close supervision with bathing Inadequate unless continually supervised Requires bathing	0 1 2 3 4	☐ 15
16	**Continence** (circle appropriate code) Full control Occasional accidents Continent by day only if regularly toileted Urinary incontinence in spite of regular toileting Regular or frequent double incontinence	0 1 2 3 4	☐ 16
17	**Memory** (circle appropriate code) Complete Occasionally forgetful Short term loss Short and long term loss	0 1 2 3	☐ 17
18	**Orientation** (circle appropriate code) Complete Orientated in home/ward, identifies people correctly Misidentifies but can find way about Cannot find way to bed or toilet without assistance Completely lost	0 1 2 3 4	☐ 18
19	**Communication** (circle appropriate code) Always clear, retains information Can indicate needs, understands simple verbal directions, can deal with simple information Cannot understand simple verbal information or cannot indicate needs Cannot understand simple verbal information and cannot indicate needs, retains some expressive ability No effective contact	0 1 2 3 4	☐ 19

20 Restlessness (circle appropriate code)

None	0	
Intermittent	1	
Persistent by day or night	2	
Persistent by day AND night	3	20
Constant	4	

21 Co-operation (circle appropriate code)

Actively co-operative	0	
Passively co-operative or occasionally unco-operative	1	
Requires frequent encouragement or persuasion	2	21
Rejects assistance, shows independent ill directed activity	3	
Completely resistive or withdrawn	4	

22 TASKS PERFORMED BY HOME HELP

Personal Care (circle appropriate codes)

Help with washing and bathing	1	22
Help with dressing and undressing	1	23
Help with shaving and hairdressing	1	24
Help with personal hygiene and toileting	1	25
Encouraging the use of aids provided	1	26
Encouraging the continuation with any exercises prescribed	1	27
Encouraging the continuation with any medication or treatment prescribed	1	28
Supervising medicines	1	29

Social Care (circle appropriate code)

Collecting pension	1	30
Collecting prescriptions	1	31
Posting and writing letters	1	32
Paying rent and other accounts	1	33
Keeping in touch with relatives	1	34
Encouraging the continuation with any hobby or social activity	1	35
Contacting GP/HV/DN/SW	1	36
Making telephone calls	1	37
Help with budgeting	1	38
Other (Please specify .....)	1	39

23 DO YOU FEEL THAT ANY OF THE ABOVE SERVICES NOT PROVIDED AT PRESENT ARE NEEDED (Circle appropriate code)

Yes	1	40
No	2	

If yes give details

.....

.....

.....

.....

OTHER HELP

24 Does the old person receive any other services in addition to the home help? (circle appropriate code)

No other service	1	41
Visits from Social Worker	1	42
Visits from Social Work Assistant	1	43
Nightsitter	1	44
Luncheon Club	1	45
Meals on Wheels	1	46
Day Centre/Social Club	1	47
Laundry	1	48
Voluntary Help/Visitors	1	49
Visits from Health Visitor	1	50
Visits from District Nurse	1	51
Bath attendant	1	52
Sheltered dwelling warden	1	53
Occupational Therapist	1	54
Chiropodist	1	55
Other (Specify)		
.....	1	56

25 In your opinion is 'at home' the best place to care for this person? (circle appropriate code)

Yes	1	
No	2	57
Don't know	3	

26 If 'no' to question 25 what place might be the most appropriate? (circle appropriate code)

Sheltered Housing with Resident Warden	01	
Old People's Home	02	
Home for Elderly Mentally Infirm	03	
Nursing Home	04	
Geriatric Ward	05	58
Psychogeriatric Ward	06	
Psychiatric Ward	07	
Other Hospital bed	08	
Other (please specify)	09	
Don't know	10	

27 Is the type of accommodation specified in question 26 being sought for this person? (circle appropriate code)

Yes	1	
No	2	59
Don't know	3	

28 If 'yes' to question 27 please indicate when application if necessary, was made or first made, if more than one application has been made for this accommodation. (circle appropriate code)

less than one month	1
1-6 months	2
6-12 months	3
12 months or more	4
Don't know	5

60

29 Any other comment about the person which may help clarify his or her situation.

61

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
IF YOU HAVE ANY QUERIES OR DIFFICULTIES PLEASE RING KEVIN McCOY ON BELFAST 650111, EXTENSION 384.

Please associate this form with the appropriate Household form.

NOTES ON THE COMPLETION OF:

SECTIONS 12-21 OF THE CENSUS FORM FOR ELDERLY PERSONS IN RECEIPT OF THE HOME HELP SERVICE ON 31 OCTOBER 1982 - FORM HH2

MOBILITY

0. Fully ambulant including stairs

Able to go up and down stairs independently. Does not require supervision. May use one handrail but not two. Must be able to manage 8 or 9 steps. Must not be unduly slow.

1. Usually independent

Walks independently without supervision on flat surfaces or on slight slope but cannot manage stairs. May use walking stick but should not require stick for support.

2. Walks with supervision

Walks without frame but needs watching for fear of falling. May use stick indoors or use handrail or furniture for support. Able to walk across room (12 feet) if accompanied but does not require physical support.

3. Walks with aids or under careful supervision

Most users of frame or tripod. If aids are lifted and only there to prevent danger of falling code 2. Also includes those who require physical support but must walk more than 3 or 4 steps regularly.

4. Bedfast or Chairfast

Unable to walk more than 3 or 4 steps. Spends virtually all the time in chair or bed. May be able to get from chair to toilet.

DRESSING

0. Correct

No assistance or supervision required. Includes ability to manage buttons and fastenings.

1. Imperfect but adequate

Dresses independently but may not always be neat (eg buttons wrongly fastened or shoes on wrong feet). May need help with laces and fastenings.

2. Adequate with minimum of supervision

Requires clothes laying out in right order. May need physical help one or two items of clothing but does not require someone in the room all the time.

3. Inadequate unless continually supervised

Requires someone to be in the room all the time and may need considerable physical assistance. But makes attempt to put some items on. May be unable to appreciate order of clothing even when items are presented correctly.

4. Unable to dress or to retain clothing

Requires to be dressed and unable or unwilling to assist by pulling garments on. May be able to help with dressing but once dressed is constantly attempting to remove clothing.

FEEDING

0. Correct unaided at appropriate times

Able to manage all foods without assistance.

1. Adequate with minimum of supervision

Requires food cutting up. Can use implements but not knife. May require encouragement or watching to ensure that food is eaten appropriately but does not require someone to supervise constantly.

2. Inadequate unless continually supervised

Needs to be sat with for a variety of reasons. May eat other peoples food, may be very messy, may eat food in strange combinations. But can feed self.

3. Requires feeding

Has to be physically fed.

BATHING

0. Washes and bathes without assistance

Does not require help getting in or out of the bath or with washing. No supervision necessary but door may be left open as precaution.

1. Minimal supervision with bathing

Washes independently but needs someone in the room when taking a bath. Does not require lifting in and out of the bath and washes self without help. May need back washing. Most people in residential care receive this degree of supervision.

2. Close supervision with bathing

Requires physical help getting in and out of bath but once in will wash most parts independently. Washes hands and face without supervision.

3. Inadequate unless continually supervised

Needs washing in the bath but will wash hands and face. Although requires some supervision with this.

4. Requires bathing

CONTINENCE

0. Full control

Toilets self independently. May be very occasionally incontinent of urine.

1. Occasional accidents

Toilets self by day but may require toileting at night. Occasional day or night accidents or slight dribbling.

2. Continent by day only if regular toileting

Has to be taken to toilet or requires bed pan. Fully continent provided this is done. May include occasional night time incontinence provided he/she is dry during the day. May take self to the toilet but has to be reminded.

3. Urinary incontinence in spite of regular toileting

Includes regular night time incontinence and occasional faecal incontinence.

4. Regular or frequent double incontinence

Must be frequent faecal incontinence. Includes faecal incontinence with full bladder control.

MEMORY

0. Complete

Not at all forgetful or only within range of normal expectations.

1. Occasionally forgetful

Forgets that he or she has done something or forgets where things have been left (eg forgets that he collected pension or that she had a bath - tendency to mislay personal possessions). But can easily be reminded and retains awareness of what happened yesterday or last week.

2. Short-term loss

Little idea of what happened yesterday or last week but retains memory of more distant past. Can talk sensibly about past, not just isolated events.

3. Short and long-term loss

No memory or only remembers isolated events which may be confused with events which took place at a different time.

ORIENTATION

0. Complete

Fully oriented in the institution or at home and appears to have a fairly good idea of where he or she is outside (eg knows where he or she is on outings). Has reasonable understanding of current events (eg comprehends news on television). Rating may be hypothetical where person does not go out of the institution.

1. Oriented in ward or at home, identifies people correctly

Easily lost outside but aware of layout of immediate surroundings. Able to recognise and name people with whom he or she has regular dealings (eg relatives and staff). Able to differentiate members of staff. Allowance should be made for blindness or partial sightedness.

2. Misidentifies but can find way about

Able to find way to bedroom and toilet without assistance but cannot apply names to members of staff (eg calls all staff by the same name or confuses names). May still recognise one or more relatives. Ability to find way does not include wanderers who come across bedroom or toilet in their travels. If physically handicapped, and therefore unable to move around independently, should show awareness of immediate surroundings. Deafness and/or speech defects can make assessment difficult.

3. Cannot find way to bed or toilet without assistance

Unable to identify people and unable to find way about. Needs help finding bedroom or toilet but may be able to find one or the other. Rate physically handicapped according to awareness of surroundings. Must retain some idea of place ie understands that he or she is in a home or in a hospital.

4. Completely lost

No idea of where he or she is. May lie down wrong way in bed unless directed.

COMMUNICATION

0. Always clear, retains information

Can carry on a normal conversation without the need to simplify. Able to cope with own affairs. Could go shopping if physically capable. If conversation is limited because of deafness or speech defects Code 1.

1. Can indicate needs, understands simple verbal directions,can deal with simple information

Understands a simplified conversation and responds appropriately. Includes those with limited intelligence and those handicapped by speech or hearing defects.

2. Cannot understand simple verbal information or cannot indicate needs

Manages one or other but not both, for understanding individual must respond appropriately. Needs can be indicated in other ways than by speech. Must be able to make the listener understand what is wanted (eg food, drink, toileting, etc).

3. Cannot understand simple verbal information AND cannot indicate needs, retains some expressive ability

Failure to understand is main criterion. Retains some expressive ability but its inappropriateness to the conversation reveals lack of understanding. Will not ask for things but will respond when spoken to(eg will say'hello'when greeted).

4. No effective contact

Does not respond to communication. May talk but this is unrelated to anything that is said. Will not respond to greeting or only inappropriately.

RESTLESSNESS

0. None

May resent restrictions and frustrations of condition but no aimless wandering or fidgeting.

1. Intermittent

Patches of restlessness during day or night but usually alright. If bedfast or chairfast, wakefulness or fidgeting constitute restlessness.

2. Persistent by day or night

Daily or nightly problem but not both. Some quiet periods but constitutes a problem. Coding should be decided on the basis of what actually occurs, rather than what might occur if the person were not sedated.

3. Persistent by day and night

Some quiet periods but restlessness constitutes a persistent problem on most days and nights.

4. Constant

Virtually no quiet periods day or night. Seems to manage with very little sleep. May sleep for half an hour at a time but no more. Rarely occurs since drugs are usually administered, particularly at night.

CO-OPERATION

0. Actively co-operative

Is helpful when being assisted. May do odd jobs when asked but this is not necessary.

1. Passively co-operative or occasionally unco-operative

Will be led and allow things to be done for him or her (eg will be washed, dressed, and fed without complaint). But shows no inclination to assist. Occasional unco-operative behaviour refers to those who have good days and bad days or who are unco-operative over just one or two activities.

2. Requires frequent encouragement or persuasion

Generally unco-operative but can be encouraged or persuaded if a little time is spent. Persuasion may not work sometimes or may depend on who does the persuading.

3. Rejects assistance, shows independent ill-directed activity

Rejects attempts to assist even if encouraged. Attempts to perform task independently but usually incorrectly (eg will not be dressed but cannot dress self although attempt is made).

4. Completely resistive or withdrawn

Rejects assistance but does not attempt to do things independently. May be aggressive or may be completely withdrawn. If passive and withdrawn does not respond in any way when physically helped (eg like washing and dressing a doll).

ANNEX F

WESTERN HEALTH AND SOCIAL SERVICES BOARD - RESEARCH STUDY ON SERVICES FOR ELDERLY PEOPLE - INTERVIEW SCHEDULE - ASSISTANT PRINCIPAL SOCIAL WORKERS/SENIOR SOCIAL WORKERS - HOME HELP SERVICE

Section A

1. Geographical area covered.

2. Staffing.

3. Procedure for dealing with applications.

4. Allocation decision.

5. Number of Home Helps in District.

6. Number of households covered in District.

7. Number of hours allocated to District.

Section B

1. What contribution to the decision-making process does the Health and Personal Social Services (NI) Order 1972 make?

2. What circulars/guidance from the Department of Health and Social Services are used in decision-making?

3. What circulars/guidance from Board Headquarters are used in decision-making?

4. a. When deciding on the allocation of the service is consideration taken of the person/people caring for the elderly person?

   b. If yes, what factors are taken into account?

   c. Does the presence of a Carer usually give lower priority for the service?

5. a. Are alternatives to the Home Help Service considered?

   b. If alternatives, what alternatives are likely to be considered?

6. a. Does a waiting list operate?

   b. If yes, give details.

7. Do you have a statement of policy which is available to staff and/or the public?

8. What are your priorities in service provision?

9. What are your review procedures?

10. Generally in what terms is 'at risk' defined?

11. Would you say that a person is more 'at risk' and therefore has a greater chance of receiving a service if his needs are of a physical nature (self care ability, general and mental health) rather than a social nature, (loneliness, social isolation)?

12. Do you see the Home Help Service as providing an acceptable alternative to residential care?

13. How many applications for the Home Help Service have been rejected during the past 12 months?

14. On what grounds have these applications been rejected?

PRIVATE AND CONFIDENTIAL

ANNEX G

FORM-RA1

CENSUS FORM (AS FOR 30 June 1982) OF ELDERLY PERSONS IN OLD PEOPLE'S HOMES.
WESTERN HEALTH AND SOCIAL SERVICES BOARD

		COLUMNS
1. NAME OF HOME		1
2. RESIDENTS REFERENCE NO		2
3. Type of Home (Circle appropriate code) OLD PEOPLES HOME 1 HOME FOR ELDERLY MENTALLY INFIRM 2		3
3a. AGE RANGE: (circle appropriate code) Under 65 1 65-69 2 70-74 3 75-79 4 80-84 5 85-89 6 90-94 7 95-99 8 100 and over 9		4
4. SEX (circle appropriate code) Male 1 Female 2		5
5. MARITAL STATUS (circle appropriate code) Single 1 Married 2 Widowed 3 Separated/Divorced 4 Don't know 9		6
6. DATE OF ADMISSION _____ (enter month and year)		7

COLUMNS

7. PLACE FROM WHICH ADMITTED (circle appropriate code)

Own Home (not sheltered housing)	01	
Own Home (sheltered housing with resident warden)	02	
Home of son or daughter	03	
Old People's Home - Board	04	
Old People's Home - Private/Voluntary	05	
Home for Elderly Mentally Infirm	06	
Geriatric Ward	07	
Psychiatric Ward	08	
Psychogeriatric Ward	09	
Other Hospital Ward	10	
Nursing Home	11	[ ] 8
Other (specify .....)	12	
Don't know	99	

8. LAST KNOWN PRIVATE ADDRESS

.....

.....

[ ][ ] 9

9. LIVING ARRANGEMENTS (circle appropriate code)

Prior to admission to home or hospital care did resident/patient:

live alone	1	
live with spouse only	2	
live with spouse and children	3	
live with children	4	
live with brothers and/or sisters	5	
live with other relations	6	
live with others	7	[ ] 10
Don't know	9	

PLEASE CONSULT THE SPECIAL NOTES OF GUIDANCE BEFORE ATTEMPTING TO COMPLETE QUESTIONS 10-19. ALL THESE QUESTIONS SHOULD BE ANSWERED.

10. MOBILITY (circle appropriate code)

Fully ambulant including stairs	0	
Usually independent	1	
Walks with supervision	2	
Walks with aids or under careful supervision	3	[ ] 11
Bedfast or chairfast	4	

		COLUMNS
11. DRESSING (circle appropriate code)		
Correct	0	
Imperfect but adequate	1	
Adequate with minimum of supervision	2	
Inadequate unless continually supervised	3	☐ 12
Unable to dress or to retain clothing	4	
12. FEEDING (circle appropriate code)		
Correct unaided at appropriate times	0	
Adequate with minimum supervision	1	
Inadequate unless continually supervised	2	☐ 13
Requires feeding	3	
13. BATHING (circle appropriate code)		
Washes and bathes without assistance	0	
Minimal supervision with bathing	1	
Close supervision with bathing	2	
Inadequate unless continually supervised	3	☐ 14
Requires bathing	4	
14. CONTINENCE (circle appropriate code)		
Full control	0	
Occasional accidents	1	
Continent by day only if regularly toileted	2	
Urinary incontinence in spite of regular toileting	3	☐ 15
Regular or frequent double incontinence	4	
15. MEMORY (circle appropriate code)		
Complete	0	
Occasionally forgetful	1	
Short term loss	2	☐ 16
Short and long term loss	3	
16. ORIENTATION (circle appropriate code)		
Complete	0	
Orientated in home/ward, identifies people correctly	1	☐ 17
Misidentifies but can find way about	2	
Cannot find way to bed or toilet without assistance	3	
Completely lost	4	

		COLUMNS
17. COMMUNICATION (circle appropriate code)		
Always clear, retains information	0	
Can indicate needs, understands simple verbal directions, can deal with simple information	1	
Cannot understand simple verbal information or cannot indicate needs	2	☐ 18
Cannot understand simple verbal information and cannot indicate needs, retains some expressive ability	3	
No effective contact	4	
18. RESTLESSNESS (circle appropriate code)		
None	0	
Intermittent	1	
Persistent by day or night	2	☐ 19
Persistent by day AND night	3	
Constant	4	
19. CO-OPERATION (circle appropriate code)		
Actively co-operative	0	
Passively co-operative or occasionally unco-operative	1	
Requires frequent encouragement or persuasion	2	☐ 20
Rejects assistance, shows independent ill directed activity	3	
Completely resistive or withdrawn	4	
20. In your opinion is this the best place for this person (circle appropriate code)		
YES	1	
NO	2	☐ 21
DON'T KNOW	9	
If "No" go to Question 22		
21. If 'yes' to question 20 is this considered (circle appropriate code)		
Permanent	1	
Short term for holiday relief period	2	
Short term for period of home crisis	3	☐ 22
Other (please specify .....)	4	
Don't know	9	
Go to Question 26		

COLUMNS

22. If 'no' to question 20 what kind of accommodation might be the most appropriate (circle appropriate code - one only)

Own Home (not sheltered housing)	01
Own Home (sheltered housing with resident warden)	02
Old People's Home	03
Home for Elderly Mentally Infirm	04
Nursing Home	05
Geriatric Ward	06
Psychiatric Ward	07
Psychogeriatric Ward	08
Other Hospital bed	09
Other (specify .....)	10
Don't know	99

[ ][ ] 23

23. Is the type of accommodation specified in question 22 being sought for this person. (circle appropriate code)

YES	1
NO	2
DON'T KNOW	9

[ ] 24

24. If 'yes' to question 23 please indicate when application, if necessary, was made or first made if more than one application has been made. (circle appropriate code)

less than one month	1
one - five months	2
six - eleven months	3
twelve months or more	4
Not applicable	5
Don't know	9

[ ] 25

25. ONLY TO BE ANSWERED IF QUESTION 22 WAS CODED '1' OR '2'

If this person was to go home which of these services would they probably need regularly. (circle appropriate codes)

Attendance at Day Hospital	1	[ ] 26
Attendance at Day Centre	1	[ ] 27
Day Care in an Old People's Home	1	[ ] 28
Attendance at Social Club or Luncheon Club	1	[ ] 29
Short stays in Old People's Home	1	[ ] 30
Home Help Service	1	[ ] 31
Night sitter service	1	[ ] 32
Meals on wheels	1	[ ] 33
Laundry service	1	[ ] 34
Visits from District Nurse	1	[ ] 35
Visits from Health Visitor	1	[ ] 36

COLUMNS

Visits from Social Worker/Social Work	1	37
Assistant	1	38
Bath attendant	1	39
Chiropody	1	40
Neighbourhood Warden	1	41
Other (specify	1	42

26. If residential accommodation is not the best place for this person, have the alternatives at Q 22 been discussed with the resident. (Circle appropriate code)

Yes	1	
No	2	43
Don't Know	3	

27. If the answer to Q 26 was 'yes' does the resident agree with the alternative being suggested

Yes	1	
No	2	44
Don't Know	3	

Thank you for completing this form. If you have any difficulties or wish clarification of any point please ring Kevin McCoy on

Belfast 650111 Extension 384

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN ANSWERED

ANNEX H

WESTERN HEALTH AND SOCIAL SERVICES BOARD - RESEARCH STUDY ON SERVICES FOR ELDERLY

INTERVIEW SCHEDULE - CHAIRMAN OF ADMISSION PANELS

SECTION A

1. Membership of panel.

2. Frequency of meeting.

3. Procedure.

4. Area covered.

5. Functions.

6. Allocation decision.

7. Number of Homes.

8. Number of Places.

SECTION B

1. What contribution to the decision making of the admission panel does the Health and Personal Social Services (NI) Order 1972 make?

2. What circulars/guidance from the Department are used by the panel in decision-making?

3. What circulars/guidance from Board Headquarters are used by the panel in decision-making?

4. a. When deciding on whom to allocate a place is consideration taken of the person/people caring for the elderly person?

   b. If yes, what factors are taken into account?

   c. Does the presence of a carer usually give lower priority for a place?

5. a. Does the allocating body consider alternatives to residential care or is it considered that this has been sufficiently explored by the social worker submitting the application?

   b. If alternatives, what alternatives are likely to be considered?

6. When allocating a place is any attempt made to achieve social balance within the Home in terms of age, background, ability etc?

7. a. Does a waiting list operate?

   b. If yes, give details.

   c. If no, does length of wait give any priority?

8. Is it usually possible to take the wishes of the applicant into account when allocating a place, for example, location?

9. What constitutes an emergency?

10. Does a 'swop system' operate?

11. HOSPITAL/COMMUNITY

   a. Are a set number of places allocated to people in hospital?

   b. If yes, what is the ratio?

12. FINANCIAL SITUATIONS

   a. Is a person considered ineligible for a Board Home on the basis of capital and income, that is, it is considered he could afford private care?

   b. If yes, at what level does a person become ineligible for a residential home place?

13. MEDICAL ASSESSMENT

   a. Are people usually medically assessed before entering residential accommodation?

   b. If yes,

      i. of what does assessment consist?

      ii. by whom is it carried out?

      iii. at what stage is it carried out?

   c. If no,

      i. is there any particular reason for not carrying out such assessment?

      ii. do you think that a medical assessment would be valuable? Give reasons.

      iii. who do you think should carry out such assessment?

      iv. at what stage do you think that medical assessment should be carried out?

Would you please give details of allocation policy with regard to the following:-

14. INCONTINENCE

a. Are people incontinent of urine admitted?

b. Are people incontinent of faeces admitted?

c. Are catheter users admitted?

d. Are people with colostomies admitted?

e. How frequent does incontinence have to be to jeopardise chances of entering residential accommodation?

15. SELF CARE

Would a person be considered ineligible for residential accommodation if he were unable to complete the following tasks and needed the assistance of staff:-

a. Getting in and out of bed.

b. Washing himself.

c. Bathing himself.

d. Dressing himself.

e. Feeding himself.

f. Using the toilet.

g. Being mobile (inside the home).

16. MENTAL STATE

a. Are there any specialist homes for the elderly mentally infirm?

b. If yes, what are the symptoms that would make a person,

i. eligible?

ii. ineligible?

c. If no,

i. what are the symptoms/conditions that would make a person ineligible for residential accommodation?

ii. what symptoms/conditions stemming from mental infirmity would be acceptable for an ordinary residential home?

iii. if a person is considered too mentally infirm for residential care what usually happens to them, as far as you know?

17. Generally in what terms is 'at risk' defined?

18. Would you say that a person is more 'at risk' and therefore has a greater chance of becoming a resident if his needs are of a physical nature (self care ability, general and mental health) rather than a social nature, (loneliness, social isolation)?

19. How many applications for residential accommodation have been rejected during the past 12 months?

20. On what grounds have these applications been rejected?

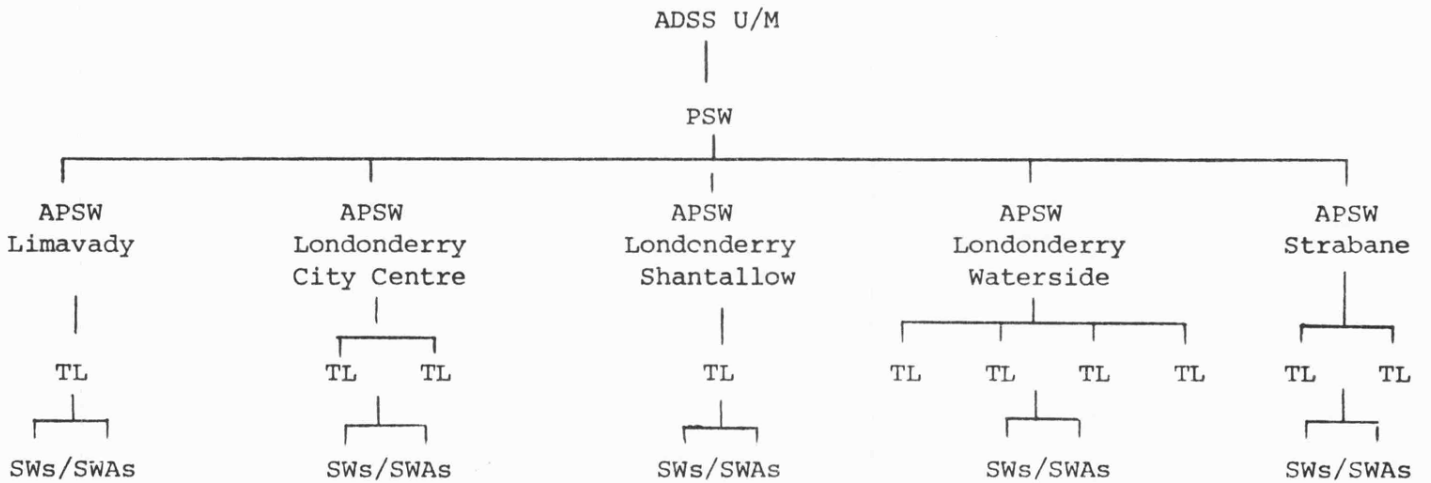
21. a. Does the allocating body have a monitoring/review function ie, after allocation and admission.

b. If yes, describe monitoring/reviewing.

c. If no, do you think monitoring/reviewing would be useful?

LONDONDERRY, LIMAVADY AND STRABANE UNIT/MANAGEMENT

ORGANISATIONAL CHART (FIELDWORK)



ANNEX I

ANNEX J

CRITERIA FOR ADMISSION TO RESIDENTIAL CARE

1. The Applicant is without accommodation and alternative suitable accommodation is not available:

OR

2. The applicant is so frail physically, that he requires personal care or supervision, which cannot be provided by relatives or the domiciliary services, or a combination of the 2.

OR

3. The applicant is at risk because of mental disorder and adequate supervision cannot be provided by relatives or the domiciliary services or a combination of the 2.

OR

4. The applicant cannot be provided with effective domiciliary care because of inadequate or isolated housing and suitable alternative housing is not available.

OR

5. The applicant is unable to accept domiciliary help or has exhausted all available domiciliary services.

OR

6. The applicant believes that his needs can be met only by residential care.

AND

7. The applicant is not confined to bed.

AND

8. The applicant will benefit from living in a residential community.

ANNEX K

THE PHILOSOPHY OF RESIDENTIAL CARE FOR THE ELDERLY

When all possible alternatives, including short-term admission to residential care have been considered there remain some elderly people for whom long term-residential accommodation appears to be the only available solution to their difficulties. Admission to residential care is a procedure which involves major changes in a person's life at a time when physical and emotional energy is diminishing. Prior to admission the social worker may indeed need to help an older person accept that there is no viable alternative to moving into a residential home and to come to terms with the changes that such a move will involve. Most elderly people do, of course, wish for a balance between independence and the security of knowing that they will receive the degree of care and attention they may need in times of illness or stress.

The majority of elderly people wish to remain in their own homes in the community for as long as possible and so dimiciliary services are provided, eg home help service, meals-on-wheels. Day care facilities are also valuable resources and enable elderly people to continue living in the community. There may, however, come a time when such support services can no longer provide the degree of security necessary for the elderly person and residential care becomes the only method of providing the necessary care.

Domiciliary support (although not adequate) and the increasing numbers living to advanced old age means that residential accommodation is mainly required for people who are older and frailer; both physically and mentally. Many persons who would have been previously regarded as suitable applicants for homes are now able to remain within the community and residential staff sometimes feel that residential homes are becoming quasi-nursing units - hence the need for clear social services department selection and admission procedures which should be known to other professions, particularly GP s and hospital staff.

The prime objective of residential care is to afford residents the maximum degree of independence, choice, freedom, comfort, privacy and security in the Unit as well as maintaining social activities and contacts within their local community. The key factor in the provision of all forms of accommodation is if the old person feels he/she has freely made the choice to move. If the older person feels rejected or has to move because of circumstances beyond his/her control he/she is far less likely to experience the move as satisfying. The social worker should not underestimate the level of strain that such circumstances may create for the client and should therefore offer the appropriate help to work through the whole process of adjustment.

EH/MN.
16.10.1980